

# RANDWICK DAY SURGERY APPLICATION/RENEWAL FOR CLINICAL PRIVILEGES

(With this application please enclose a copy of your CURRENT MEDICAL BOARD or DENTAL BOARD REGISTRATION, a copy of your CURRENT MEDICAL DEFENCE UNION MEMBERSHIP and a copy of your RADIATION CONTROL LICENCE I:20 for dental radiology)

I, \_\_\_\_\_  
(Full given names and surname in block letters)

**Please circle the applicable option below**

**Option 1**

I wish to apply for listing as a Visiting Medical/Dental Practitioner to the Randwick Day Surgery Unit.

**Option 2**

I wish to apply for renewal as a Visiting Medical/Dental Practitioner to the Randwick Day Surgery Unit.

**For renewal purposes: Please update the following information requested if any details have changed in the last three years**

Residential Address \_\_\_\_\_

\_\_\_\_\_ Tel: \_\_\_\_\_ Mob: \_\_\_\_\_

Practice Address \_\_\_\_\_

\_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Address for correspondence/reports (*Please indicate*) HOME  PRACTICE

Date of Birth \_\_\_\_\_

Provider Number \_\_\_\_\_

**PROFESSIONAL DATA:**

| Initial Qualifications: | Degree/Diploma | Issuing Body | Year |
|-------------------------|----------------|--------------|------|
|-------------------------|----------------|--------------|------|

\_\_\_\_\_

Additional Qualifications \_\_\_\_\_

\_\_\_\_\_

**Type of current practice:**

(a) General Practice YES/NO

Special interests \_\_\_\_\_

(b) Registered Specialty \_\_\_\_\_

Specialist Registration in NSW YES/NO

PRESENT HOSPITAL APPOINTMENTS:

Public \_\_\_\_\_

\_\_\_\_\_

Please read the following declaration before proceeding with application/renewal

**DECLARATION – PLEASE READ CAREFULLY**

1. I attach a copy of the professional indemnity insurance and NSW Medical/Dental Board Registration. I understand that I am obligated to provide evidence of these documents annually.
2. I confirm that I have completed sufficient continuing education and procedures to ensure that I am competent to carry out the scope of my clinical privileges.
3. I acknowledge, in accordance with **the NSW Health Private Hospitals and Day Procedures Act 1988** and NSW Health Infection Control Policy **2002:45**, that it is my responsibility to ensure that I know my HIV, Hep B and Hep C status, and the status of all of my assistants, at all times. Furthermore I give an undertaking to the Medical Advisory Committee of RDS that I will not perform any procedure, nor allow my assistants to assist in theatre if our serology is returned with a positive result.
4. I understand and will comply with all aspects of the NSW Health Infection Control Policy **2007\_036** and RDS policy and Procedures and that a breach of these may result in my privileges being revoked.
5. I understand and agree to my visiting assistants being trained appropriately for dental procedure in accordance with NSW Health Infection Control Policy **2007\_036** and Infection Control Guidelines for Oral Health Facilities **GL2005\_037**. In the event of an assistant being deemed unsuitable I understand that my procedure will be postponed or cancelled until I arrange for an acceptable assistant.
6. In the event of a sharps injury I agree to complete all necessary documentation and consent to serology and follow up as may be determined by the directors.
7. **I agree to co-operate with all auditing requirements agreed by the Medical Advisory Committee in regards to the facilities external Accreditation Body, NSW Dept of Health and Health Fund Contractual requirements.**
8. **I agree to acknowledge the authorization given to the appointed Director of Nursing by the Medical Advisory Committee in all matters pertaining to the NSW Dept of Health regulations, accreditation and contractual agreements with health funds.**
9. I agree to complete in total all documentation relating to the patients medical record and further documentation that may be required for the administration of the centre.
10. I confirm that I have not been subject to any disciplinary action or professional sanctions neither imposed on me by my professional organizations nor have I been involved in any criminal investigations or had a criminal conviction recorded against me.
11. I confirm that I am in good health and I am not suffering from any physical or mental condition that would preclude me from carrying out the scope of my clinical privileges safely and competently. I also confirm that I do not suffer from a substance abuse problem.
12. I acknowledge that I have been given a copy of the RDS Guidelines for Admission of Patients and have noted the pre-admission requirements for all patients being admitted to RDS including the special requirements for patients over 55 years of age.
13. I declare that I am the person named in this application and that to the best of my knowledge the statements herein contained are true in substance and fact. I give my permission for the directors of RDS to discuss my clinical competence with the executive of other hospital where I hold clinical privileges.

**Please note: Applicable to all dentists**

I understand that I will be charged a facility fee for each fifteen minutes that a dental procedure, for a privately insured patient, exceeds one and a half hours. This charge cannot be passed on to the patient.

**I understand that I may have my privileges revoked as a Visiting Medical Practitioner in the following circumstances:**

- o Persistent failure to comply with Policy and Procedures of RDS
- o Failure to comply with all relevant Australian Standards Codes of Practice and Legislation
- o Infection Control Breaches
- o Re-use of Single Use Items

**I understand that there is a process at Randwick Day Surgery to revoke Clinical Privileges when the 6 month probationary period has already expired:**

- o A proposal to revoke privileges to be discussed at MAC meeting
- o A written warning from the MAC to be sent to the practitioner outlining concerns
- o Practitioner interviewed by Chairman
- o Continued failure to comply with Policy and Procedures will result in privileges being revoked
- o The MAC reserves the right to discontinue privileges of practitioners where there is evidence of the above breaches.

**Day Surgery Privileges sought: Please tick**

- Anaesthesia
- Dental procedures
- Oral Surgical procedures
- Other

ANTICIPATED VOLUME AND FREQUENCY OF WORK

*(Please detail anticipated requirements)* \_\_\_\_\_

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Dentists Performing Implant Surgery – Please note the following:-**

As a Visiting Medical Officer to Randwick Day Surgery I agree to the following conditions set by the Medical Advisory Committee on May 24<sup>th</sup> 2005

**1:** I understand that prior to commencing a procedure at Randwick Day Surgery I will endeavour to ensure that I have all relevant materials, imaging/X-rays and implants for the

procedure

2: I will check my proposed procedure details on the Randwick Day Surgery consent form with my patient prior to their admission into theatre and sign accordingly.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return application form to the Administration of Randwick Day Surgery.

**FOR OFFICE USE ONLY**

**Medical Director**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date MAC Confirmation \_\_\_\_\_

Field of Practice \_\_\_\_\_

Privileges Granted \_\_\_\_\_

Date for Reapplication \_\_\_\_\_

Letter of Approval Sent Date \_\_\_\_\_