

# RANDWICK DAY SURGERY APPLICATION 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 1:20 for dental radiology)

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

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

Residential Address and Telephone Number \_\_\_\_\_

\_\_\_\_\_

Practice Address and Telephone Numbers \_\_\_\_\_

\_\_\_\_\_

Address for correspondence/reports (Please indicate) HOME  PRACTICE

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

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

## PROFESSIONAL DATA:

Initial Qualifications:	Degree/Diploma	Issuing Body	Year
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\_\_\_\_\_

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 \_\_\_\_\_

\_\_\_\_\_

Other Hospitals to which you admit patients

\_\_\_\_\_

**Please read the attached declaration before proceeding with application**

## **DECLARATION –PLEASE READ CAREFULLY**

1. I attach a copy of my 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 procedures, nor allow my assistants to assist in theatre if our serology is returned with a positive result.

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.

- 4. I understand and agree to my visiting assistants being trained appropriately for dental and invasive procedures 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.**
5. 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.
6. I agree to participate in all Quality Assurance activities carried out in the facility
7. 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.
8. I confirm that I have not been subject to any disciplinary action or professional sanctions neither imposed on me by my professional organisations nor have I been involved in any criminal investigations or had a criminal conviction recorded against me.
9. 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.
10. 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.
11. 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 hospitals where I hold clinical privileges

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

- Persistent failure to comply with Policy and Procedures of RDS
- Failure to comply with all relevant Australian Standards Codes of Practice and Legislation
- Infection Control Breaches
- 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:**

- A proposal to revoke privileges to be discussed at MAC meeting
- A written warning from the MAC to be sent to the practitioner outlining concerns
- Practitioner interviewed by Chairman
- Continued failure to comply with Policy and Procedures will result in privileges being revoked
- 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)

(a) Anticipated Medicare Item Numbers to be used (if applicable)

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 I will be held responsible for ensuring my assistants to implant procedures are trained appropriately for their position, including knowledge of the particular implant set being used, scrubbing, sterile gowning, gloving and aseptic technique within a theatre environment.

**2:** 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

**3:** I understand that I must confirm the number of implants and allow preparation time for implant set-up when arranging a booking

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

I understand that another check will be carried out in theatre prior to the procedure commencing. Any relevant imaging data or X-rays will also be verified at this time.

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\_\_\_\_\_