

RANDWICK DAY SURGERY

The Chairman
Medical Advisory Committee
Randwick Day Surgery
2 Eurimbla Avenue
Randwick 2031

Date: / /

New Address Details:

Tel. w: _____

Mobile: _____

Email Address: _____

I, _____

hereby apply for renewal of my clinical privileges as _____
at the Randwick Day Surgery for the period of 5 years.

1. I hereby confirm that the details of my previously lodged application are unaltered and the scope of the clinical privileges sought remains unchanged from my previous application
2. I attach a copy of my professional indemnity insurance, NSW Medical/Dental Board Registration and EPA Certificate. I understand that I am obligated to provide evidence of these documents annually.
3. 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.
4. I acknowledge, in accordance with the NSW Health Private Hospitals and Day Procedures Act 1988 and NSW Health Infection Control Policy 2007_036, 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.
5. I understand and 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.
6. **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.**
7. 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.
8. I agree to participate in all Quality Assurance activities carried out in the facility
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 organisations nor have I been involved in any criminal investigations or had a criminal conviction recorded against me.
11. I confirm that I am of 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.
11. 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.

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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.

Signature: _____

Name: _____

Date: _____

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 24th 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.

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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 procedure commencing. Any relevant imaging data or X-rays will also be verified at this time.

Signature: _____

Name: _____

Date: _____

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 _____