WAIKIKI PRIVATE HOSPITAL

ABN 48437579849

Application for Appointment as a Visiting Medical Officer (VMO)/Visiting Dental Officer to Waikiki Private Hospital

I hereby apply to Waikiki Private Hospital for appointment as a Visiting Medical Officer/Visiting Dental Officer.
To support my application, I submit the following information (**Please print** and attach separate sheets if insufficient space)

1. PERSONAL DETAILS

Professional Title	
Surname:	
Given names:	
Former names (Including maiden name)	
Residential Address:	
	Post Code:
Telephone:	**Mobile:** **Fax:**
Pager:	
Date of birth:	
Practice Name:	
Main Practice Address:	
	Post Code:
Telephone	**Fax:**
Email/Web	
Address for Correspondence:	

1. CLINICAL PRIVILEGES

A) SPECIALITY IN WHICH APPOINTMENT IS SOUGHT:

B) CLINICAL PRIVILEGES REQUESTED:

Admitting	**Anaesthetic**
Operating	**Diagnostic (imaging/Pathology etc)**

2. QUALIFICATIONS

(Please attach any relevant documentation)

Degree/Fellowship	Conferring Body	Year

3. CURRENT APPOINTMENTS

Facility	Appointments

4. PAST APPOINTMENTS

Facility	Appointments

5. NONIMATION ALTERNATIVE IN EVENT OF EMERGENCY

In the event that I am unable to be contacted for a clinical emergency, the person nominated as agreed to be contacted:

Name: ……………………………………………………………

Contact phone numbers: ………………………………………………..

Alternative Contact: …………………………………………………………..

6. REFERENCES:

Please list names, addresses, and telephone numbers of three professional referees.

Name	Address	Phone and Fax Number

7. REGISTRATION

Please supply details of your current registration with the Medical Board of western Australia. Please attach a copy of the current Registration.

Registration Number …………………….

8. INSURANCE

Do you have current Medical/Dental Indemnity Insurance at the appropriate level?

Yes **No**

Please provide details: ……………………………………………………
Please attach a copy of your Medical Insurance Policy/Schedule

9. DISCLOSURE

a) **Have you ever had any restrictions placed on your Medical/Dental Registration?**
If you answered yes to the above, please provide details on as separate sheet. (Including details of the restriction and what period during which the restrictions apply/applied.
Yes **No**

a) **Have your clinical privileges ever been suspended or revoked at another hospital?**
If you answered yes to the above please provide details on a separate sheet.
Yes **No**

b) **Have there ever been any serious adverse findings made against you by the Health Insurance Commission, Medical Board, a Health Care Commission/ Body, a coroner or any other profession disciplinary body?**
If you answered yes to the above, please provide details on a separate sheet.
Yes **No**

c) **Criminal Record Check – Have you been convicted or pleaded guilty to a serious sex or violence offence or an offence involving dishonesty?**
If you answer yes to the above please provide details on a separate sheet
Yes **No**

d) **Do you consent to Waikiki Private Hospital undertaking criminal record checks on you as required by law?**
Yes **No**

10. DECLARATION

I warrant and represent that information provided by me to Waikiki Private Hospital in this application and in connection with the application is accurate and complete and is not misleading or deceiving or likely to mislead or deceive.

I understand that if I have provided misleading or deceptive information or information which is likely to mislead or deceive that Waikiki Private Hospital Management may (in its absolute discretion) consider that I do not have 'current fitness' under the Hospital By- Laws.

I agree that I will notify the Director of Clinical Services of Waikiki Private Hospital of any material changes to the information provided by me in connection with this application as soon as possible after the change.

I acknowledge that I have provided with, and read a copy of the Hospital By-Laws. If appointed, I agree to abide by the policies and By-laws of Waikiki Private Hospital. Additionally I am prepared to participate in teaching, research and quality improvement act ivies of Waikiki Private Hospital and in on-call roster arrangements as appropriate.

Signature: ………………………………………… **Date**: ……………….

Witness Name: ……………………………………………………………………….

Witness Signature: ……………………………… **Date**: …………………

Please ensure that this form is fully completed and that the following documentation is included, otherwise your application will be delayed:

- Separate **CV** Attached (please note, your CV will be forwarded to the Credentialing Committee at Waikiki Private Hospital, who will be asked to provide recommendation regarding your application).
- **Two** written **references**
- **Copy** of **qualifications**
- **Copy** of current **Medical/Dental Defence Society Membership**
- **Copy** of current certificate of **Medical/Dental Registration**.
- Copy of **Radiation Safety License, and/or laser Safety License** if appropriate.
- **Copy** of **Working with Children Check** (WCC)