APPLICATION FOR CREDENTIALING AND RE-CREDENTIALING AT ALBANY COMMUNITY HOSPICE

I am applying for: ◯ Initial Credentialing ◯ Re-credentialing

1. PERSONAL DETAILS

Family Name				
Given Names				
Preferred Name				
Professional Address				
Private Address				
Postal Address				
PHONE	**Home**		**Mobile**	
	Work		**Fax**	
EMAIL	**Work**		**Home**	
Residency Status			**Visa Type**	

(Australian Citizen / Permanent / Temporary Resident) *If Applicable*

2. QUALIFICATIONS

Major Qualification	**University / Organisation**	**Year / Country**
Other Qualifications	**University / Organisation**	**Year / Country**

3. REFEREES

Please provide details for TWO referees. Hospice may seek formal referee reports form those named below.

REFEREE 1			
Name		**Position currently held**	
Professional Address			
Telephone		**Fax**	
Email			

REFEREE 2			
Name		**Position currently held**	
Professional Address			
Telephone		**Fax**	
Email			

4. SCOPE OF PRACTICE

I seek Credentialing and Scope of Practice as follows:

☐ Specialist - General Practitioner

☐ Specialist - Other ***Speciality:*** _____

☐ Vocational Doctor in Training ***Supervisor:*** _____

5. REQUIRED DOCUMENTS CHECKLIST

Please ensure you have attached the following documents to your application:

☐ Evidence of current Indemnity Insurance

☐ Evidence of Continuing Professional Education **OR** ☐ Evidence of enrollment in relevant training program if you are a vocational (Registrar) doctor in training

☐ Police Clearance

☐ Hand Hygiene certificate - this can be completed at www.hha.org.au

☐ Immunisation screening form completed and relevant evidence attached

6. APPLICANT ENDORSEMENT

I fully understand that any untrue statements in, or omissions from, this application constitute cause for denial of privileges or cause for termination of my contract. I agree to abide by the policies and guidelines applicable to Albany Community Hospice, to which I am applying for Scope of Practice.

DECLARATION

I declare that all of the information provided is true and correct, and I agree to comply with the conditions attached to this application for Credentialing and Scope of Practice.

I consent to Albany Community Hospice, obtaining relevant information on past performance or any conditions placed on my practice, including the nature of any unresolved complaints.

Name: _____

Signature: _____ **Date:** _____

Please return this form to admin@albanyhospice.org,au with the relevant forms. Thank you

FOR OFFICE USE ONLY

Name of Applicant: _____

Applying for: ☐ Initial Credentialing ☐ Re-credentialing

Document	Received	Reviewed	Initial
Indemnity Insurance	☐	☐	
CPD Evidence **OR** Evidence of enrolment in relevant training program	☐	☐	
Police Clearance	☐	☐	
Hand Hygiene Certificate	☐	☐	
Immunisation screening form completed and relevant evidence	☐	☐	
AHPRA Registration Check		☐	

FOR RE-CREDENTIALING

Please provide details of performance during the previous credentialed period:

_____

_____

Contract Approved / Effective: **Date:** _____

Re-credentialing Due: **Date:** _____

Contract sent to GP **Date:** _____