AESTHETIC DAY SURGERY

14 Kensington Street
Kogarah NSW 2217

Tel: (02) 9553 9905
Fax: (02) 9553 9924
Email: pgoh@aestheticdaysurgery.com.au

APPLICATION FOR ACCREDITATION OF VISITING MEDICAL PRACTITIONERS

Aesthetic Day Surgery

APPLICATION FOR ACCREDITATION

Surname: Please print	
First Names: Please print	
Business / Rooms Address:	
Telephone Fax Mobile	T: F: M:
Email Address:	
Home Address:	
Preferred mailing address:	Business: ☐ Residential: ☐
Provider Number:	
D.O.B.:	
Working With Children Check Number:	WWC:
Undergraduate qualifications: Degrees/Diplomas: Year of Graduation: University:	
Post Graduate qualifications: Degrees/Diplomas: Year of Graduation: University:	
Post Graduate qualifications: Degrees/Diplomas: Year of Graduation: University:	
Post Graduate qualifications: Degrees/Diplomas: Year of Graduation: University:	

Current Hospital Appointments	
Previous experience	Training Hospitals: Overseas Post Graduate Experience: Recent Publications:
Medical Leadership positions	
Details of clinical activity and outcomes undertaken in last 12 months. Details of completion of CME requirements from appropriate institution	
Details of involvement in clinical audits, research, peer review activities and continuing medical programs	

Accreditation sought in the following categories:

☐ Specialist Practitioner

☐ GP Assistant

☐ Registrar Assistant

Registered Specialty / Sub-Specialty:

Accreditation (Please tick):

☐ Permanent: to 30/6/2025 ☐ Temporary from __/ __/ __ to __/ __/ __

Clinical Privileges are sought in the field(s) of: (Not applicable to surgical assistants)

☐ Anaesthesia

☐ Plastic & Reconstructive / Cosmetic

☐ Other:

Professional Referees – name, contact telephone number and email address:

1.

2.

3.

Evidence of Vaccination:

Please provide evidence of vaccination for:

- ☐ COVID-19
- ☐ Diphtheria, Tetanus, Pertussis (dTpa)
- ☐ Hepatitis B
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Varicella
- ☐ Influenza

Hand Hygiene

Please provide current Hand Hygiene certificate

Registration:

Please record your current registration number with AHPRA

Number:

Are there any restrictions attached to this registration? ☐ No ☐ Yes

If yes provide details:

Medical Defence:

Please record the name of your Medical Defence/Professional Indemnity Insurer and **provide a copy of your certificate of currency**

Registration No.:

Paid To:

Please attach your usual Curriculum Vitae

Declarations: (please circle)

I **have / have not** had disciplinary action against me or sanctions imposed by an organisation or registration board.

I **have / have not** been involved in a criminal investigation and have / have not had a conviction against me.

I **have / have no** physical or mental condition or substance abuse problem that could affect my ability to exercise my requested scope of clinical practice.

I declare that these statements are true and correct. In applying for accreditation I agree to abide by the policies and procedures of the Aesthetic Day Surgery and any terms and conditions that may be applied to my appointment by the Medical Advisory Committee.

I authorise a member of the Credentialing Committee to seek relevant information to support my application regarding my professional performance and fitness to practice.

I agree to participate in educational and quality assurance activities when requested.

Signature:

Print Name:

Date:

Required attachments:

- ☐ Evidence of Vaccinations
- ☐ Copy of Hand Hygiene certificate
- ☐ Copy of Medical Defence Insurance certificate of currency
- ☐ Copy of current Curriculum Vitae
- ☐ Copies of post graduate qualifications

Please note: ***Confirmation of Accreditation will be advised via email once approved by the Medical Advisory Committee***