APPLICATION FOR APPOINTMENT
East Brisbane Day Hospital

Surname: _____ Title: _____

Given Names: _____

Date of Birth: _____ / _____ / _____

Place of Birth: _____ Citizenship: _____

Permanent Resident: **Y / N**

Languages other than English: _____

Practice Details:

Address: _____ Suburb: _____

P/code: _____ Phone Number: _____

Email address: _____

Home Details:

Address: _____ Suburb: _____

P/code: _____ Phone Number: _____

Email address: _____

Medical Registration (Australia and Overseas)
Include all past and present, including current, lapsed, suspended, restricted and deregistered registration.

DATE ISSUED	REG NO.	TYPE	DATE EXPIRES

Year first registered in Queensland: _____

Are you recognized as a specialist in Queensland by the Commonwealth Department of Health? **Y / N**

Membership of specialist Association: _____

Registration Number: _____ Provider Number: _____

Medical Defence Insurance Company: _____

Medical Defence Number: _____ Expiry date: _____/ _____/_____

Please circle appropriate option

Have there ever been or are there currently pending any claims, settlements or judgments against you? Y / N

Has your medical defence organisation ever excluded any specific area of practice, or terminated or denied coverage? Y / N

If the answer to either of the above two questions is yes, please provide a full explanation of the details of each matter on a separate sheet and attach.

Do you have a disability? Y / N

If yes, please describe below.

Does this disability compromise your ability to perform any of the cognitive and physical functions related to the clinical work you may be required to perform?

Y / N / N/A

If yes, please describe below.

Have you ever been the subject of disciplinary action in the course of your work as a medical practitioner and have your clinical privileges ever been reduced, altered, withdrawn, suspended or not renewed at another hospital or day procedure centre?

Y / N

If yes, please describe below.

Have there ever been any adverse findings made against you which would be relevant to your appointment (for example breach of insurance/medical laws, sexual misconduct)?

Y / N

Have you ever been convicted of any criminal charges (other than motor vehicle offences)?

Y / N

If yes, please describe below.

_____

_____

_____

Have you ever been convicted of a drug or alcohol-related offence?

Y / N

If yes, please describe below.

_____

_____

_____

Clinician Signature: _____ Expiry date: _____ / _____ /_____

QUALIFICATIONS	DEGREE/DIPLOMA	ISSUING BODY	YEAR
BASIC			
POST GRADUATE			
OTHER			

Please attach your curriculum vitae and a copy of your current practicing certificate.

Please list all previous and present academic and clinical appointments (in chronological order since completion of medical degree)

APPOINTMENT	COMMENCED	DISCONTINUED

Nature of present practice: _____

Specialties:

_____

_____

_____

Nature of accreditation sought:

☐ SURGICAL ☐ ANAESTHETICS

Scope of Clinical Practice

Please specify surgical procedures you wish to perform.

_____

_____

_____

_____

Back up service in case of emergency:

Surname: _____ Title: _____

Given Names: _____

Practice Details:

Address:_____ Suburb: _____

P/code:_____Phone Number: _____

Email address: _____

Home Details:

Address:_____ Suburb: _____

P/code:_____Phone Number: _____

Email address: _____

Professional References *(please provide all the details in the box below)*
Please provide details for three referees who can attest that recent practice is consistent with the criteria contained within the By-Laws for the accreditation sought. The referred provided should be familiar with your current professional capabilities and should not be personally or financially related to you.

Please note that referees will be contacted and may be asked to provide a verbal and/or written reference.

NAME	ADDRESS	PHONE NO	POSITION
1.			
2.			
3.			

I hereby agree to abide by the By-Laws of East Brisbane Day Hospital for visiting Medical Practitioners as published and circulated from time to time, statutory and commonwealth legislation relevant to the work of this hospital.

The details I have provided in this application are correct and I provide permission for any of the details in this application to be verified with other organisations if required.

Signature of applicant: _____Date: _____ / _____ / _____

Hospital Use Only:

Contact with professional referees:

_____

_____

_____

_____

_____

Appointment confirmed for a _____ year period, commencing _____

Signed: _____ Date of confirmation: _____/_____/_____