Clinical Privileging Application Form

***Are you providing patient treatment, care, procedures or advice? ***

✓ **YES – Please complete the form** ✘ **NO - DO NOT complete this form.**

I hereby apply to Griffith University Health Group for Appointment as a Privileged (credentialed) Practitioner within Griffith University, including the Clinical Trials Unit, and seek appointment for the category and privileges indicated. To support my application I submit the following information.

1. Personal Details

Title (eg: Dr, Ms, Mr, A/Prof, Prof)			
Surname			
Given Name(s)			
Any former names (including maiden name)			
Date of Birth			
Griffith Staff Number (if applicable)	S		
Medicare Provider No. (Griffith University site specific)		**Medicare Prescriber No.** (if applicable)	
Radiation Licence No. (Dental Clinic only)		**Expiry:**	

Residential Address			
	Post Code		
Telephone		**Mobile No.**	
Email Address			
Postal Address: *If the same as your residential address, write 'as above'*			
	Post Code		

Practice Address (if applicable)	
	Post Code
Telephone	

2. Clinical Practice Sought

You must mark at least one box in each section (2.1, 2.2, 2.3, 2.4 and 2.5):

2.1	Activity(ies) that you wish to undertake at Griffith University or Clinical Trial Unit	
	☐	Clinical Practice (Treatment Rights)
	☐	Clinical Teacher/Supervision
	☐	Clinical Research
	☐	Nitrous Oxide Inhalation Sedation (*Dental Clinic only*) a) you must attach your Statement of Attendance from ADAQ CPD and Training Centre; and b) the Head of School and Clinic Director must recommend approval of this application on Page 13

2.2	Your employment arrangement with Griffith University		Definition
	☐	**Casual, Sessional, Fixed Term or Continuing Employee**	A Griffith University staff member: • Academic staff – employed to teach, supervise or assess students in the Griffith Health Clinics • Non-academic staff – employed on a casual basis to undertake clinical practice in the Griffith Health Clinics
	☐	**Service Practitioner**	A Griffith staff member employed principally to undertake clinical practice engaged in a non-academic capacity under a fixed term individual common law employment contract.
	☐	**Private Practice**	A Griffith staff member seeking approval to undertake private practice, where this practice is undertaken outside of (i.e., in addition to) their assigned Griffith workload.
	☐	**IPP** Intra-mural Professional Practice ***IPP _____%** *(you must complete percentage)*	A Griffith staff member seeking to undertake private practice within assigned Griffith workload. ***NOTE**: You **must attach** written approval from your Head of School **AND** the Clinic Director which includes the **IPP percentage**
	☐	**External Practitioner**	A non-Griffith employee seeking approval to undertake clinical practice.

2.3	External clinical practice outside of Griffith University (applies to Griffith Staff Only)	
	☐	I have approval to practice/treat patients outside of Griffith University. Please provide approval from the PVC (H) with your privileging application
	☐	I am seeking to undertake practice/treatment of patients outside of Griffith University
	☐	Not applicable

2.4	Clinical Privileging Period sought	
Clinical Privileging Period sought: (Please tick)	☐	Maximum 3-year period requested
	☐	Other from _____ to _____ *(insert date)* *(insert date)*

2.5	Clinical privileging sought in the following discipline and speciality areas *(You can tick more than one box)*	

Dentistry	
☐	General Dentistry
☐	Nitrous Oxide Inhalation Sedation
☐	Specialisation (please indicate below)

Other Oral Health	
☐	Oral Health Therapist
☐	Dental Prosthetist
☐	Dental Hygienist
☐	Other (please specify below)

Medicine	
☐	General Practitioner
☐	Specialisation (please indicate below)

Dietetics	
☐	General
☐	Specialisation (please indicate below)

Physiotherapy	
☐	General
☐	Area of Clinical Interest (if applicable) (please indicate below)

Speech Pathology	
☐	General
☐	Specialisation (please indicate below)

Psychology	
☐	General
☐	Specialisation (area of endorsement - please indicate below)

Other Profession	
☐	
☐	
☐	

3.1. Qualifications (Please attach your CV and any relevant documentation to support your application)

- **Non-AHPRA** registered professions – please complete Section 3
- *AHPRA registered professions **do not** need to complete this Section, please go to Section 4*

Degree/Fellowship	Conferring Body	Year

3.2. Details of Membership of Professional Associations (if applicable)

3.3. Current Appointments

Organisation	Appointments

3.4. Past Appointments (up to 5 years)

Organisation	Appointments

4. Clinical Research

Section 4 is to be completed if you indicated at Section 2 that you are applying to undertake Clinical Research.

4.1 Project Details

Project Title	
Full Name (and Title) of Chief Investigator &/or Responsible Site investigator (if not yourself)	
Has an ethics application been submitted/approved?	☐ Yes, approved - Approval number _____ ☐ Yes, Submitted ☐ No
Proposed start and end date of the Project	

4.2 Please provide details of any additional clinical qualifications you may have specific to this research:

Qualification	Conferring Body	Year
GCP Training		
***Other** *Please specify, eg Venepuncture; IATA Training, First Aid etc		

4.3 Your Role in the Project

Principal Investigator	☐
Associate Investigator	☐
Research/Study Co-Ordinator	☐
Research Assistant	☐
Registered Nurse	☐
Student	☐
Other (specify)	☐
In any of these roles, will you be supervising students **If "Yes", please answer Section 4.4 on next page, if "No" go to Section 4.5**	Yes / No

4.4 If you are supervising Students, it is your responsibility to ensure that their expertise and qualifications are consistent with the roles they are undertaking. How will you ensure this?

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4.5 Please detail your role in this research, including specific clinical interventions and procedures you intend to perform and any special provisions that need to be provided by the Griffith Health Clinics or the Clinical Trial Unit to support the intended clinical service or research intervention.

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4.6 Please detail how your qualifications and expertise are relevant and suitable for your role and work in this project.

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5. Clinical Supervision Arrangements

Please detail the arrangements that will be in place, through which **you** will receive clinical supervision, whilst undertaking clinical services within the Griffith Health Clinics

☐ Tick this box if this is ***not applicable*** to your role

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6. Scope of Practice (must be completed if you selected Clinical Practice/Treatment Rights or Clinical Teacher/Supervision in Section 2)

Please detail the range of Clinical services which you intend to deliver within the Griffith Health Clinics and any special provisions that need be provided by the Griffith Health Clinics to support the intended clinical service or research intervention.

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7. References (to be completed by **non-Griffith** University staff)

If you are **not** a Griffith University staff member please provide the name and email address of at least two professional referees who can attest that your recent practice is consistent with the clinical privileges sought.

The referees provided should be familiar with your current professional capabilities.

Please note that your referees will be contacted and asked to provide a written reference. References may be provided by you in writing.

The Committee reserves the right to seek additional referees if required.

**** Normally Griffith University staff will not need to provide references, however approvers to the CPC process reserve the right to request references if they deem necessary.***

Referee Name	Email Address & Phone Contact
	Email:
	Phone:
	Email:
	Phone:

8. Registration (relevant to **registered** health professionals only)

Please supply details of your current professional registration:

Registration Body: ……

Registration Number: …… Expiration: ……..

Specialty: ……..

Conditions Imposed on Registration (if any): ……

☑ **Please attach a copy of the current Registration Certificate**

9. Insurance

- **Casual, Sessional or Fixed Term** Griffith staff members are usually covered under the University insurance policies whilst undertaking their role as part of their approved employment duties.

- **Private Practitioners** (Griffith staff members working **outside** of workload) and **External Practitioners** (non-Griffith employees) are required to carry their own Professional Indemnity **and** Public Liability insurances.

- Griffith staff working under an **Intra-mural Professional Practice (IPP)** arrangement (that is, working within workload) while covered under the University Professional Indemnity and Public Liability Insurances are encouraged to carry their own insurance.

- **Clinical Trials** and **Clinical Research** with ethics approval are also usually covered by the University Professional Indemnity and Public Liability Insurances. However, please clarify your obligations with your Principal Investigator.

Please note that by submitting this application you consent to a representative from Griffith University contacting your defence organisation / insurer to verify that you maintain appropriate indemnity coverage for the privileges sought.

Do you have current Professional Indemnity Insurance?	Yes ☐	No ☐
Do you have current Public Liability Insurance?	Yes ☐	No ☐

Please provide details and any conditions:

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Please attach ☑ a copy of your current Certificate of Currency for your Insurance Policies (a tax invoice is NOT acceptable evidence)

10. **Disclosure** (must be completed by all applicants)

10.1 Have you ever had any restrictions placed on your Professional Registration?

Yes ☐ No ☐

If you answered yes to the above, please provide details (including details of the restriction and what period during which the restrictions apply/applied):

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10.2. Have you previously been refused clinical privileges at another health care facility?

Yes ☐ No ☐

If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note, a senior executive of the Griffith Health Group may contact the facility.

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10.3 Have your clinical privileges ever been withdrawn, suspended or not renewed on the basis of clinical competency at another facility?

Yes ☐ No ☐

If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note, a senior executive of the Griffith Health Clinics may contact the facility.

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10.4 Have there ever been any serious adverse findings made against you which would be relevant to your appointment (for example: breach of insurance / medical laws, professional misconduct, sexual assaults or assault) by the, Health Insurance Commission, a Health Board, a Health Care Complaints Commission/Body, a Coroner, a Court or any other professional disciplinary or similar body?

Yes ☐ No ☐

If you answered yes to the above, please provide details:

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10. Disclosure (continued)

10.5 Are you currently under investigation for matters of conduct, performance or impairment

Yes ☐ No ☐

If you answered yes to the above, please provide details

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……..

10.6 Criminal Record Check – Have you been convicted of or pleaded guilty to a criminal offence including a serious sex or violence offence or an offence involving dishonesty or drugs (other than a spent conviction)?

Yes ☐ No ☐

If you answered yes to the above, please provide details:

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10.7 Is there any other information that you should disclose that is relevant to your application?

Yes ☐ No ☐

If you answered yes to the above, please provide details:

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11. Representation and Warranty (Acceptance of Terms & Conditions)

- The information provided by me to the Griffith Health Group in this application and in connection with this 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 Griffith University may (in its absolute discretion) consider that I do not have "current fitness" to practice within Griffith University or Clinical Trial Unit.
- I agree that I will notify the Head of School in which my clinic resides (or other relevant person such as Clinic or Clinical Trial Director) of any material changes to the information provided by me in connection with this application as soon as possible after the change.
- I understand that my appointment, if granted, will be valid for 3 years or earlier if considered necessary by either party, or for the duration of a specific research project.
- I agree, annually, to provide copies of current professional indemnity insurance (if applicable), registration and other documents as requested.
- If appointed, I agree to abide by Griffith Policies and Guidelines. .
- If appointed, I agree to practice within the Scope of Practice defined by the registering body and specified by the Clinic/School in which I practice.
- I confirm that I am competent and qualified to perform any interventions specified in this application.
- I agree that should any notifiable events occur, I will immediately notify the Head of School or other relevant person such as Clinic Director or Clinical Trial Unit Director.

Applicant's Name: _____

Applicant Signature: _____

Date: _____

12. RECOMMENDATIONS AND SUPERVISION

APPLICANT'S NAME: _____
(please write applicant's name above)

12.1 Clinical Privileging:

Clinic Director/ Clinical Trial Unit Director

This Application for Clinical Privileging is recommended for approval:

Name: _____ Signature:_____ Date: _____

AND/OR

Head of School

This Application for Clinical Privileging is recommended for approval

Name: _____ Signature:_____ Date: _____

12.2 Supervision (if applicable):

I confirm that supervision arrangements will be made and maintained for the applicant in accordance with standards accepted by the relevant professional accreditation body.

…….
Clinic Director/ Clinical Trial Unit Director

*Complete Section 12.3 **only** if **IPP** has been ticked in Section 2.2*

12.3 Intra-mural Professional Practice (IPP)

Percentage IPP: _____%

Head of School

This Application for IPP is recommended for approval:

Name: _____ Signature:_____ Date: _____

AND

Clinic Director/ Clinical Trial Unit Director

This Application for IPP is recommended for approval:

Name: _____ Signature:_____ Date: _____

13. Consideration of Clinical Privileging Application

Office Use Only

Recommended / Not Recommended by Clinical Privileging Committee

See Attached email approval of Chair.

Reasons for Non-recommendation (if applicable):

_____

_____

Endorsed by Pro-Vice Chancellor (Health):

See Attached email approval of PVC.

14. CHECKLIST (incomplete applications will not be considered)

Please ensure that this form is fully completed and that the following documentation (where applicable) is included with this application:

- ✓ Provider/prescriber numbers *(all applicants – Page 1).*
- ✓ AHPRA Registration or Self-Regulated Body Accreditation Certificate *(all applicants)*
- ✓ Curriculum vitae *(all applicants)*
- ✓ Radiation or other licensing details where applicable *(Dental Clinic only)*
- ✓ Qualifications (Section 3) (*non-AHPRA registered applicants only*)
- ✓ Currency of first aid qualification (*non-AHPRA registered applicants*)
- ✓ Current criminal record checks including Blue Card (*non-AHPRA registered applicants*)
- ✓ Current Insurance Policy (including indemnity and medical malpractice insurance) (*refer to Section 9*);
- ✓ Contact details from at least two professional referees where applicable (*non-Griffith staff only*)
- ✓ Other requirements as specified by the relevant Clinic Director/HOS
- ✓ Ensure that your application has the support of your Clinic Director / Head of School and they have signed Section 12 or attached an email confirming their approval to your application.

Privacy

Griffith University collects, stores, and uses personal information only for the purposes of administering employment, recruitment and payroll and to maintain historical employment and payroll records. The information collected will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. For further information, consult the University's Privacy Plan.

HOW TO SUBMIT THIS APPLICATION

When complete, please sign the form and submit (with relevant documentation) to:

The Secretary
Clinical Privileging Committee
G40_8.41, Griffith Health Executive
Gold Coast Campus
Griffith University QLD 4222
Tel: 07 5678 0187
Email: privileging@griffith.edu.au