MANLY WATERS
PRIVATE HOSPITAL

17 Cove Avenue, Manly NSW 2095
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Website: www.machealth.com.au

APPLICATION FOR LISTING AS A VISITING PRACTITIONER

To the Hospital Director,

I, _____
(Surname) *(Christian Names (In Full)*

wish to apply for listing as a Visiting Practitioner to **Manly Waters Private Hospital.**

I agree to co-operate in implementing policies and procedures, which are required to provide the highest patient care, in accordance with Hospital by-laws, Australian Medical Association Code of Conduct and Ethics, Manly Waters Private Hospital policies and procedures and compliance to Universal and Standard Precautions.

Residential Address, Telephone Number _____

and Mobile Number _____

_____

Practice Address, Telephone and Fax Numbers _____

and E-mail Address _____

_____

_____

Professional Data

	Degree/Diploma	***Issuing Body***	***Year***
Initial Qualifications:			
Additional Qualifications:			

Initial Date of Reg. in NSW: _____ Reg. No.: _____

Provider No.:- _____

Date of Birth: _____ Current Medical/Dental Defence Ins. Co.: _____

Please attach copy of most recent NSW Medical/Dental Board Registration Certificates

Type of Current Practice

If General Practice, does it include surgery or Specialty Procedures? If so, state experience in these:

_____

_____

_____

Registered Specialty: _____

_____

Present Hospital Appointments (at date of application)

Public: _____

Other Hospitals to which you admit patients: _____

_____

Please tick the privileges you seek:

Hospital Privileges: Medical ☐ Surgical ☐

Theatre Privileges: Major ☐ Minor ☐ Anaesthesia ☐

Other: Paediatric ☐

Volume and Frequency of expected:
Please detail anticipated requirements

Admission Frequency: _____

Specialised Equipment Utilisation: _____

Reviews will be done regularly to assess volume and frequency of work. The purpose of this review is to maintain optimal utilization of hospital beds and theatres.

You are required to inform the hospital of a replacement Practitioner (who *already has visiting privileges*) to attend patients in your absence.

Two references provided from:

Name Position Contact Number

_____

_____

Signature: _____ Date: _____

OFFICE USE ONLY

Hospital Director

All Credentials Verified: Current Medical Registration and Medical Insurance proof provided Yes ☐ No ☐

Comments, if any: _____

Signature: _____ Date: _____

Approved ☐ / *Not Approved* ☐

Chairman Medical Advisory and Sub Credentialing Committee

Comments, if any: _____

Signature: _____ Date: _____

Approved ☐ / *Not Approved* ☐

Confirmation / Non Confirmation of Applicant in writing

Comments, if any: _____

Signature: _____ Date: _____