BENDIGO HEALTH

HEALTHY COMMUNITIES AND WORLD CLASS HEALTHCARE

CARING | PASSIONATE | TRUSTWORTHY

Shared Maternity Care Affiliate Accreditation

Triennium 1 January 2017 – 31 December 2019
General Practitioners and Obstetricians

PERSONAL DETAILS

Title: ____ **Given Names:** ______________________________ **Surname:** _________________________

☐ Female ☐ General Practitioner ☐ FRACGP

☐ Male ☐ Obstetrician

QI&CPD No.: ____________ Languages spoken (other than English): _______________________________

PRACTICE DETAILS

	Primary Practice: Preferred mailing address ☐ Yes ☐ No *If no please complete preferred mailing address section*	**Additional practice**	**Preferred mailing address** (only complete if different from primary practice)
Practice name			
Address Suburb Postcode			
Phone			
Fax			
Mobile			
Provider number			
Preferred email address*			

*****Please note your privacy is assured. Your details will not be shared and will only be used for non-clinical communications from the Shared Maternity Care Collaborative Hospitals e.g. Newsletters, Educational activities etc.*

For information only

A. PROFESSIONAL REQUIREMENTS

All applicants for Shared Maternity Care Affiliate accreditation must provide evidence of:

- ☐ Current Unrestricted Medical Registration in Victoria
  Please attach copy of Medical Board Registration
- ☐ Current Medical Indemnity Insurance membership
  Please attach copy of confirmation Certificate of Medical Indemnity Insurance
  You are advised to ensure that your medical indemnity covers the provision of shared maternity care.
- ☐ For General Practitioners – Current Practice Accreditation against RACGP Standards for General Practice (e.g. by AGPAL or GPA)
  Please attach copy of Practice Accreditation Certificate
- ☐ For General Practitioners – Curriculum Vitae
  This should include details of undergraduate and postgraduate experience and qualifications in obstetrics, gynaecology and women's health. Please include dates, fulltime equivalent loading, role and responsibilities/ tasks and the institute/s these were undertaken.

B. PROFESSIONAL REFEREES (medical)

All applicants for Shared Maternity Care Affiliate accreditation must provide two professional referees (medical) ideally one referee should be a current shared maternity care affiliate or obstetrician.

	Referee 1	Referee 2
Name		
Contact Number		
Email		
Profession	☐SMCA ☐Obstetrician Please specify hospital:	☐SMCA ☐Obstetrician Please specify hospital:

C. PATHWAYS TO ACHIEVE ACCREDITATION

To be considered for accreditation applicants must fulfil **one** of the following criteria **(please attach copies of certificates of postgraduate qualifications where required)**:

1. ☐ Primary qualification in last 5 years (recertification required) of one of:
- Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology (DRANZCOG) or
- Certificate in Women's Health from RANZCOG Date attained:_________________

2. ☐ Primary qualification more than 5 years ago of one of:
- Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology (DRANZCOG) (recertification required);
- Diploma Obstetrics Royal Australian College of Obstetrics and Gynaecology (RACOG) (no recertification required); or,
- Certificate in Women's Health from RANZCOG Date attained:_________________

Plus Recent involvement in provision of antenatal care. Please list sites involved:

3. ☐ FRANZCOG Date attained:______________________

4. ☐ FRACGP plus Significant Experience as an Antenatal Care Provider
(Please include details in your CV). Applications for accreditation will be considered on an individual basis for GPs who can demonstrate significant experience/qualifications/professional development/accreditation in the provision of antenatal care.

For information only

D. AGREEMENT/UNDERTAKING

I understand that in assessing my application for appointment as Specialist Shared Maternity Care Affiliate Medical Practitioner, the health service will make additional enquiries as to my suitability for the position.

I understand the health service may conduct a routine criminal history check in relation to my current and previous place/s of residence. Yes ☐ No ☐
I agree to familiarise myself with relevant hospital by-laws, policies and procedures and to abide by them. Yes ☐ No ☐
I accept that the health service will obtain information relevant to my application from the Australian Health Practitioner Regulation Authority and any other board regulating health practitioners, whether in Victoria or elsewhere. Yes ☐ No ☐
I authorise the health service to obtain information relevant to my application from my current and any previous medical indemnity organisation/insurer. Yes ☐ No ☐
I authorise the health service to obtain information relevant to my supervision requirements (where applicable). Yes ☐ No ☐
I authorise the health service to seek information from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation. Yes ☐ No ☐
I agree to abide by the organisations and state and national confidentiality and privacy laws and policies and understand that breaches may result in the cessation of my appointment. Yes ☐ No ☐
I agree to notify the director of medical services/medical leader of any event/situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to medical registration matters, or otherwise. This includes matters about which I consider that the director/medical leader would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, reductions in registration or insurance). Yes ☐ No ☐
I agree to comply with relevant ongoing educational/certification programs, (for example, college or relevant professional association/body) and to furnish details to the health service on an annual basis as requested by the director of medical services/medical leader. Yes ☐ No ☐
I agree to participate in an annual performance appraisal. Yes ☐ No ☐
I agree to promptly notify the director of medical services/medical leader of any adverse clinical incident I am involved in, or become aware of. Yes ☐ No ☐
I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me. Yes ☐ No ☐
Should any question as to my scope of clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that scope of clinical practice is appropriate. Yes ☐ No ☐

For information only

NB: Applications will not be processed without copies of *all* supporting documentation.

Checklist

☐ Copy of Medical Board Registration
☐ Copy of confirmation Certificate of Medical Indemnity Insurance
☐ Copy of Practice Accreditation Certificate
☐ Copy of evidence of postgraduate qualifications
☐ Curriculum Vitae
☐ Signature

For information only