Geelong DAY SURGERY

APPLICATION FOR CREDENTIALING and PRACTICE RIGHTS

(CLINICAL PRIVILEGES)
Dental Assistant

Name of practitioner

Surname

Given Names

Application for practice rights (Clinical privileges)

This is a: New application Renewal/reapplication Altered scope of practice

Please attach the following to this form:

2. Current curriculum vitae
3. Certified copy of Certificate III in Dental Assisting or equivalent
4. Passport
5. Driver's Licence
6. National/International Police Check (less than 12 months)
7. Copy of Business Insurance from relevant Dental Practitioner
8. Working with children check (if available)
9. COVID 19 immunisation (x2 + booster)
10. Flu immunisation history (Medicare)
11. Confirmation Letter from relevant Dental Practitioner that the applicant (dental assistant) is employed by their Dental Practice

Professional Contact Details

Clinic/Practice Address:

Clinic Phone:

Clinic Email:

Personal Contact Details

Postal Address:

Personal Mobile

Personal Email:

PBS Prescriber number

21 – 29 Princes Hwy, Norlane VIC 3214 03 5222 1560 reception@geelongdaysurgery.com.au geelongdaysurgery.com.au

Prior history

Have you ever been formally disciplined (by an employer or other organisation) in the course of your work as a dental assistant?	Yes	No
Has your right to practise ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body?	Yes	No
Have you ever been convicted or found guilty of any criminal offence, including a drug- or alcohol-related offence?	Yes	No
Are you the subject of current or pending criminal charges?	Yes	No

If you answered yes to any of the above, please provide full details. Or, if you prefer, provide the information in a sealed envelope marked 'Confidential for Director of Nursing only' appended to this application, and indicate here that additional information is provided separately in this manner.

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Continuing Professional Development

Do you undertake continuing professional development education?	Yes	No

Please list some professional development activities undertaken in the last year

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Health status

Do you have a disability or health issue that:	Yes	No
• may impact on your ability to perform any of the cognitive and physical functions that would fall within the scope of practice that you are seeking in this application?		
• may require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application?		
• may be relevant to determining your scope of practice?		

If you answered YES, please provide details of the disability or health issue and its likely, or possible, impact on your ability to carry out the sought scope of practice. Details of any special equipment facilities or work practices required should be included.

This information can be provided on this form or, alternately, you can provide the information in a sealed envelope marked 'Confidential for Director of Nursing only' appended to this application. Indicate here if additional information is being appended.

This information is sought to enable an assessment to be made as to whether you can safely perform the inherent and reasonable requirements of the work that you seek to perform at the health service or whether any reasonable adjustments might be required to ensure you can work at the health service in a way that ensures patient safety.

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Referee

Please provide details of **a registered dentist, credentialed at Geelong Day Surgery, who can provide a reference**

Name

Current position

Phone (BH) Mobile

Email address

Name

Current position

Phone (BH) Mobile

Email address

Name

Current position

Phone (BH) Mobile

Email address

Agreement/undertakings

I understand that in assessing my application for appointment as a medical practitioner, Geelong Day Surgery will make additional enquiries as to my suitability for the position.

I understand Geelong Day Surgery will conduct a routine police check.	Yes	No
I authorise Geelong Day Surgery to seek information from my referees as to my past experience, performance and current fitness to practise.	Yes	No
I agree to familiarise myself with relevant Geelong Day Surgery, Policies and procedures and to abide by them.	Yes	No
I authorise Geelong Day Surgery to obtain information relevant to my application from my current and any previous medical indemnity organisation/insurer.	Yes	No
I authorise Geelong Day Surgery to obtain information relevant to my supervision requirements (where applicable).	Yes	No
I authorise Geelong Day Surgery to seek information from other persons as the health service considers appropriate, including any relevant health service or training organisation.	Yes	No
I agree to abide by Geelong Day Surgery's 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 Nursing of any event/situation that may impact on my ability to act as a Dental Assistant. This includes matters about which I consider that the Director of Nursing/ Director of Medical Services 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, or reductions insurance).	Yes	No
I agree to notify the Director of Nursing of any action taken by another healthcare organisation to suspend, terminate or vary my rights of practice. I undertake to do this within 10 working days of such action being taken.	Yes	No
I agree to promptly notify the Director of Nursing of any adverse clinical incident I am involved in, or become aware of.	Yes	No

Declaration

I hereby declare that the information contained in this application is true and correct.

Date

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