



# APPLICATION FOR APPOINTMENT

## Visiting Medical Practitioner (VMP) or Non-Medical Visiting Practitioner (VP)

<b>Name</b>		<b>D.O.B</b>
<b>Private Address</b>		<b>Phone</b>
<b>Rooms Address</b>		<b>Phone</b>
		<b>Fax</b>
<b>After Hours Contact Phone / Mobile</b>		<b>Email</b>
<b>Category of Approval Sought (Admitting G.P., Consulting Specialist, Radiographer, etc.)</b>		
<b>Doctors only, are you seeking:</b> Admitting rights <input type="checkbox"/> and/or Consulting rights <input type="checkbox"/>		<b>Non-Medical Practitioners:</b> Right to provide other service (e.g. Radiology, Speech) as stated: .....
<b>Qualification</b>		<b>Memberships</b>
<b>Hospital Affiliations</b>		
<b>Indemnity Insurer *</b>		<b>Ins Due Date *</b>
<b>Provider Number</b>		<b>Registration No *</b>
<b>Details of Continuing Education Activities</b>		
<b>Names and contact details of 2 referees</b>		
1.		
2.		
<b>Name and contact details of a VMP or VP approved by Wolper Jewish Hospital who can cover you if you are unavailable or uncontactable:</b>		
<b>Have you ever had your appointment suspended or refused at any other hospital</b>		<b>Yes <input type="checkbox"/> No <input type="checkbox"/></b> If yes please provide details
<b>Copy of Hand Hygiene Australia training certificate within last 12 months attached</b>		<b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>
<b>Copy of Covid-19 Vaccination certificate attached</b>		<b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>

### DECLARATION

I, ....., the undersigned, on approval by Wolper Jewish Hospital, do hereby agree to abide by the By-laws (as may be amended from time to time) and Regulations of the Hospital. Pursuant to Clause 9 & 10 of the By-laws I agree to keep current professional indemnity insurance and will notify the Hospital immediately of any change in my indemnity cover or circumstance that may give rise to a claim in respect of a patient's admission in the Hospital. I understand that approval status will be reviewed every 5 years, from time to time or as otherwise stated. I will maintain my vaccination status in line with the Australian Immunisation Handbook and NSW Health requirements.

I also confirm that I have received and read the following.

- Hospital By-laws
- Clinical Governance for Doctors Summary
- Open Disclosure Policy – Online training: <http://vhimsedu.health.vic.gov.au/opendisclosure/topics/topic4/page1.php>
- Antimicrobial Stewardship Policy
- Hand Hygiene Policy
- Consumer Participation Policy
- Admission of an Inpatient Policy
- Emergency Procedure Summary

Signed..... Dated.....

<b>Approved by Medical Advisory Committee</b>	<b>Approved by Board</b>
Signature ..... Date .....	Signature ..... Date .....