Application for General Privileges

IntraCare

You wish to make an application for general privileges at IntraCare. To progress your application please complete this form and submit it along with the required supporting documents (as set out at the bottom of this application) to the IntraCare Credentialing Governance Committee.

IntraCare is under no obligation whatsoever to consider any person's application.

First name: _____ Surname: _____

Known as: _____ DOB: _____ *dd/mm/yyyy*

Home address: _____

Work address: _____

Phone: *mobile* _____ *home* _____

Healthcare providers where you currently practise: _____

_____

Professional Registration

Medical Council of NZ Registration number: _____ Expiry date: _____

Medical Council of NZ Registration type: _____

Vocational Registration in: *if applicable* _____

MOH health provider index number: _____

ACC provider number: _____ Practising Certificate current? ◯ Yes ◯ No

Radiation Use Licence (if applicable)

Do you use/propose to use radiation in the course of your practice at IntraCare? ◯ Yes ◯ No

Do you hold a Use Licence under the Radiation Safety Act 2016? ◯ Yes ◯ No

Use Licence expiry date: _____ Please provide a copy of the Use Licence.

CME

Do you participate in a re-certification programme? ◯ Yes ◯ No Do you participate in medical audit? ◯ Yes ◯ No

Please supply evidence of this, eg. vocational college MOPS

Previous Practice and Application

Have you had an application to practise at any other healthcare provider denied? ◯ Yes ◯ No
If yes, please detail below:

_____

Have any allegations or complaints ever been made relating to your competence, conduct or clinical practice? ◯ Yes ◯ No
If yes, please detail below:

_____

Is your competence, conduct or clinical practice being investigated by any other healthcare provider? Has it ever been investigated by another healthcare provider? If yes, please provide details below: ◯ Yes ◯ No

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Have you ever had your right to practise at any other healthcare provider suspended or terminated? If yes, please detail below: ◯ Yes ◯ No

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Scope of Practice

What is your scope of practice under the HPCA Act?

Have there ever been any restrictions or conditions placed on your practice by any other healthcare provider? If yes, please detail below. ◯ Yes ◯ No

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Has the Medical Council (or other authority) required you to undergo any competence reviews or are you under any investigation from the Medical Council (or other authority) into your medical practice? If yes, please detail below. ◯ Yes ◯ No

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Has the Medical Council (or other authority) ever cancelled or suspended your registration or APC (or equivalent)? If yes, please detail below. ◯ Yes ◯ No

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Are you facing or have you ever previously faced any disciplinary charges? If yes, please detail below. ◯ Yes ◯ No

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Has any adverse finding ever been made in any disciplinary charge against you? If yes, please detail below: ◯ Yes ◯ No

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Are you or have you ever been subject to any allegation of negligence or professional misconduct? If yes, please detail below: ◯ Yes ◯ No

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Are you or have you ever been involved in an ACC treatment injury claim which has resulted in criticism of your practice? If yes, please detail below: ◯ Yes ◯ No

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Are you or have you ever been involved in any adverse event investigation or HDC investigation? If yes, please detail below: ◯ Yes ◯ No

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Please disclose below any findings of breach of code of the Health and Disability Service Consumers Rights by you as found by the Health and Disability Commissioner.

Are you or have you ever been the subject of any action or findings by a medical college or specialist association or a coroner? If yes, please detail below: ◯ Yes ◯ No

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Have you ever been the subject of a criminal investigation or conviction? Are you facing any criminal investigations or convictions currently? If yes, please detail below: ◯ Yes ◯ No

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Clinical Activities

How many hours do you spend in specialist practice per week?

Please provide details of the type and range of procedures you wish to undertake using IntraCare or related facilities:

Please provide details of the type and range of procedures that fall within your Medical Council scope of practice that you **do not wish** to undertake using IntraCare facilities:

Please provide the name of two referees and their contact details from within or similar to your area of practice.

Please describe the state of your health, including any current or previous personal circumstances (e.g. bereavement, trauma or addictions), mental or physical condition or substance abuse problem with the potential to affect your fitness to practise safely, or performance or behaviour

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Any other matters offered in support of the application? Please detail below:

Privacy Consents

By submitting this application, the applicant is deemed to give the consents set out below. If you do not wish to consent to any of the items below, please do not submit an application.

I consent to the Personal Information and Health Information (as those terms are defined in the Privacy Act 2020 and the Health Information Privacy Code 2020, respectively) about me supplied on this and related forms, or otherwise collected by IntraCare, being collected, used and disclosed for the following purposes:

a) Considering this application.

b) In the interests of patient safety.

c) Ensuring the delivery of safe and high quality health services.

d) Any other purpose set out in the document IntraCare Specialist Bylaws 2023 and the Specialist Medical Services Agreement as amended or updated from time to time, (collectively, "**Purposes**").

I consent to IntraCare obtaining Personal and Health Information about me ("**Information**") from other sources (such as my referees, current or previous colleagues, other healthcare providers where I practise or have practised, my medical or surgical College or specialist association, the Medical Council, the HDC and any other authority deemed appropriate and relevant by IntraCare ("**Third Parties**").

I authorise Third Parties to disclose Information to IntraCare for any Purpose and authorise IntraCare to disclose Information to Third Parties for any Purpose.

I understand and agree that the Information provided by Third Parties may be provided in confidence as evaluative material and might not be disclosed to me.

I understand my Information will be kept secure by IntraCare and that I am entitled to ask for a copy of such Information and to ask for it to be corrected if I think it is wrong. I will contact the Credentialing Coordinator at IntraCare in order to do so.

I consent to the Information being retained by IntraCare for the Purposes, and acknowledge that after that time, the Information will be securely destroyed.

Acknowledgments

By submitting this application, the applicant is deemed to acknowledge the items below. If you do not wish to acknowledge any of the items below, please do not submit an application.

I acknowledge the following:

a) My application will be considered in accordance with the processes set out in the IntraCare Specialist Bylaws.

b) In the event of my application being declined, IntraCare is under no obligation to state reasons and there is no right of appeal against any such decision.

c) I have read and understood the IntraCare Specialist Bylaws.

d) If my application is approved, I will be asked to enter into a Specialist Medical Services Agreement with IntraCare (which will include an obligation on me to abide by the IntraCare Specialist Bylaws).

e) I will not be granted credentialed status if I do not enter into a Specialist Medical Services Agreement.

Declarations

By submitting this application, the applicant is deemed to make the declarations set out below. If you do not wish to make any of the declarations below, please do not submit an application.

I declare that:

a) The information contained on this application is accurate and complete.

b) I am competent and trained to perform the techniques in the broad groups that I have stated.

I understand that the truth of the information provided by me is essential to and will be relied upon by IntraCare and if I have falsified or withheld any information, this may be grounds for the immediate termination of my credentialed status (if granted).

This application is submitted by me, together with supporting documents on the

_____ day of _____ , 20_____.

Signed: _____

Please provide:

1. Application form
2. Current CV
3. MPS / Indemnity Insurance Certificate
4. Radiation Use Licence (if applicable)