Re-Credentialing Application Form

IntraCare

Please complete this form to re-apply at IntraCare for Credentialing and submit it along with the required supporting documents (as set out at the bottom of this application) to the IntraCare Clinical Governance Committee.

Please note 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* _____

Scope of practice: _____

MOH health provider index number: _____

ACC provider number: _____

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.

Indemnity

Indemnity organisation: _____

Membership number: _____ Expiry date of membership: _____

Please provide a copy of your certificate and cover of membership

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 been denied or current practice been suspended or terminated? If yes, please detail below: ◯ Yes ◯ No

_____

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 there been any restrictions or conditions placed on your scope of practice by the Medical Council or other authority? 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? ◯ Yes ◯ No
If yes, please detail below.

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

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?

Is there any change to the range of procedures you wish to undertake using IntraCare or related facilities? ◯ Yes ◯ No
If yes, please detail below:

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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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: _____