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, Acknowledgments and Declarations

By submitting this application, I acknowledge, authorise, consent, and declare the following. If I do not agree, I will not submit this application.

I consent to personal information and health information (as defined in the Privacy Act 2020 and the Health Information Privacy Code 2020) about me (**Information**), whether provided by me or otherwise obtained by IntraCare (including from Third Parties as described in the IntraCare Specialist Bylaws (as amended from time to time)), being collected, used and disclosed for the Purposes as defined in the IntraCare Specialist Bylaws, including:

a) assessing and processing this application;

b) protecting patient safety;

c) ensuring the delivery of safe and high-quality health services;

d) assessing, granting, reviewing and maintaining clinical privileges and Approved Areas of Practice, and undertaking credentialling, clinical governance, quality assurance and risk management activities;

e) enabling IntraCare and its related entities to operate effectively; and

f) any other Purpose set out in the IntraCare Specialist Bylaws or Specialist Medical Services Agreement.

I acknowledge and agree that IntraCare may collect Information about me from Third Parties (as described in the IntraCare Specialist Bylaws), including, for example, referees, current or former colleagues, healthcare providers or facilities where I practise or have practised, relevant professional bodies and regulatory authorities.

I acknowledge and agree that this application and the IntraCare Specialist Bylaws constitute notification to me for the purposes of Information Privacy Principles 3 and 3A of the Privacy Act 2020 and Rules 3 and 3A of the Health Information Privacy Code 2020, and that IntraCare may collect Information from Third Parties on an ongoing basis for the Purposes without providing further notice to me at the time of each collection. To the extent permitted by law, IntraCare may rely on any applicable exceptions to those notification requirements.

I authorise and agree that IntraCare may obtain, verify and collect Information about me from any Third Party for the Purposes, authorise Third Parties to disclose Information to IntraCare for the Purposes, and authorise and agree that IntraCare may use and disclose Information to Third Parties for the Purposes.

I understand and agree that Information may be provided to IntraCare by Third Parties in confidence, including evaluative material, and that such Information may not be disclosed to me to the extent permitted by law.

I understand that providing Information is necessary to assess this application and to grant and maintain clinical privileges, and that failure to provide requested Information may result in refusal of this application or the restriction, suspension or termination of any privileges granted.

I understand that my Information will be held securely by IntraCare and that I am entitled to request access to and correction of my Information in accordance with the Privacy Act 2020 and the Health Information Privacy Code 2020 by contacting IntraCare's Privacy Officer or Credentialing Coordinator. IntraCare may refuse access to Information where permitted by law, including in relation to evaluative material provided in confidence.

I consent to my Information being retained by IntraCare for as long as necessary to fulfil the Purposes and comply with legal and operational requirements, after which it will be securely destroyed or de-identified.

I acknowledge that my application will be considered in accordance with the processes set out in the IntraCare Specialist Bylaws (as amended from time to time), and that IntraCare may, at its discretion, decline this application and is not obliged to provide reasons for its decision, with no formal right of appeal.

I acknowledge that I have read and understood the IntraCare Specialist Bylaws, that if my application is approved I will be required to enter into a Specialist Medical Services Agreement incorporating those Bylaws, and that I will not be granted credentialled status unless I enter into that agreement.

I declare that the information contained in this application and any supporting material is true, accurate and complete, that I am appropriately trained, qualified and competent to perform the procedures and techniques within the scope of practice I have identified, and that IntraCare will rely on this information in assessing my application and in granting and maintaining clinical privileges. I acknowledge that providing false, misleading or incomplete information, or failing to disclose relevant information, may result in the refusal of this application or the suspension, restriction or termination of any clinical privileges granted.

Signed: _____ Date: _____

Please provide:

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