External allied health practitioner: mutual recognition application

**Allied Health Services**

Use this form to apply for mutual recognition of previously approved credentialing and defined scope of clinical practice for external health practitioners to practice within MNH facilities.

In submitting this form, you are providing your consent for information regarding your credentials and SoCP to be disclosed by Metro North Hospital and Health Services in the following circumstances:

* for publication in a credentialing register on the Queensland Health Electronic Publishing Service (QHEPS)
* for disclosure between Hospital and Health Services and the Department of Health for a purpose associated with the approval, amendment or refusal of your credentials and SoCP, including, for example, as part of the mutual recognition process of your credentials and SoCP.

# Section 1: Applicant

## Contact details:

|  |  |
| --- | --- |
| **Surname:**  |  |
| **Given Name/s:**  |  |
| **Previous surname:** (if it appears on certificates) |  |
| **Birth details:** | Date:       Place:       |
| **Professional address:**  |  |
| **Preferred postal address:**  |  |
| **Email:**  |  |
| **Telephone:**  | Business:       Mobile:       |
| **Current position:**  |  |
| **Emergency contact:** | Name:       Phone:       |

## Credentialing sought (as discussed with Profession-specific manager):

|  |  |
| --- | --- |
| Health Practitioner profession:  |  |
| Requested scope of clinical practice: |  |
| MNH facility/service locations:  | [ ]  TPCH [ ]  Redcliffe [ ]  STARS[ ]  RBWH [ ]  COH [ ]  Caboolture/Kilcoy/Woodford  |
| Frequency and time period of requested practice: | [ ]  Only for periods of leave relief / not frequently[ ]  Frequent and regular service provision *(please specify)*:      [ ]  Other *(please specify)*:       |
| Professional supervision: |       |

## Supporting documentation (attach copies of):

[ ]  Original application and letter of approval for which you are seeking mutual recognition

[ ]  Current documentation of evidence required for original application (registration, insurances etc.)

[ ]  Other information not included in original application (e.g. new qualifications, recent CPD, etc.)

* <List attachments>
* <List attachments>
* <List attachments>

|  |
| --- |
| Applicant’s Declaration |
| I declare that all the following statements are **TRUE** or **FALSE^** as indicated. | **N/A** | **True** | **False** |
| My right to practise has never been denied, restricted, suspended, terminated or otherwise modified by any health care organisation (including overseas organisations, health facilities, registration bodies, professional associations or other official bodies). | [ ]  | [ ]  | [ ]  |
| A professional association has never refused to renew my membership. | [ ]  | [ ]  | [ ]  |
| I participate in the continuing professional development program, maintenance of professional standards program, or similar, of my professional body and I am current with the requirements of that program.  | [ ]  | [ ]  | [ ]  |
| I have no physical or other condition or substance abuse that may limit my ability to exercise the scope of practice which has been granted / requested. | [ ]  | [ ]  | [ ]  |
| I have never claimed professional indemnity | [ ]  | [ ]  | [ ]  |

### ^If you answer “FALSE” to any of the above statements please attach relevant documentation.

|  |
| --- |
| I,      , will provide Metro North Hospital and Health Service with evidence of currency of registration (if applicable), continuing professional development, membership of professional bodies and indemnity insurance on an annual basis.I authorise Metro North Hospital and Health Service to conduct a criminal history check and aged care check (if required).I am prepared to participate in a professional support program (supervision, peer supervision or mentoring) with a supervisor approved by the profession-specific manager.I declare that the statements contained in this application are correct. In applying for appointment I agree to adhere to all policies, procedures and Code of Conduct applicable within Metro North Hospital and Health Service, and current State and Federal Laws. I undertake to immediately notify the Chair of the Allied Health Credentialing and Defining Scope of Clinical Practice Committee if my clinical privileges are retracted, withdrawn or altered at any other hospital or day procedure centre. I authorise Metro North Hospital and Health Service, its officers and agents to seek information as to my past experience, performance and current fitness and the validity of my responses to the above questions.Signed : Date:      Witness Signature: Witness Name:        |

# Section 2: Credentialing endorsement (must be completed prior to submission)

## Proposed clinical supervisor\*

|  |  |
| --- | --- |
| Name: |       |
| Position: |       |
| Signature: |  | Date:       |

*\*Note: where the practice has not previously been performed by the relevant Health Practitioner profession, the clinical supervisor should be from the profession that would traditionally carry out the practice*

## Work Unit/Facility Manager^

|  |  |
| --- | --- |
| Recommended scope of clinical practice:  | Description of the clinical area/s and scope in which the applicant will be required/granted scope to practice *(mandatory)*:      |
| Systems access  | List the clinical systems applications and patient information the applicant will be required to access (e.g. The Viewer; EDIS):      |
| Frequency of practice to be granted: | [ ]  Only for periods of leave relief / not frequently[ ]  Frequent and regular service provision *(please specify)*:      [ ]  Other *(please specify)*:       |
| Name: |       |
| Position: |       |
| Signature: |  | Date:       |

## Allied Health profession-specific manager^

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| [ ]  I have checked the application for completeness and witnessed the originals/certified copies of evidence (identification, qualifications, registration/membership certification, indemnity insurance, VPD immunity) *(incomplete / incorrect applications will be returned)*[ ]  I have obtained / verified the applicant’s references*At least one (1) referee report must be attached using the ‘Credentialing application: referee report’ template*.[ ]  I have interviewed the applicant (OPTIONAL)[ ]  I have attached endorsement from the Director of Allied Health (DAH) at the MNH facility/service in which the applicant proposes to practice *(via email OR signature in section 2.4 below)* |
| **Profession-specific manager recommendation**:I confirm that the services to be provided are in line with the Clinical Services Capability of the identified MNH facility/ facilities: [ ]  Yes [ ]  NoApplication: [ ]  Supported [ ]  Not supportedComments:       |
| Name: |       |
| Position: |       |
| Signature: |  | Date:       |

***^ If Work Unit/Facility Manager and Profession-specific manager are the same, complete both sections 2.2 & 2.3.***

## Director/s of Allied Health

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| --- |
| DAH:       Facility/Service:       Date:       |

# Once all signatures have been obtained, submit to: metronorthalliedhealth@health.qld.gov.au

# Section 3: Primary Decision Maker approval

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| ***Office Use Only*** |
| **Primary Decision Maker Office** | **To be completed PRIOR to assessment by PDM:** |
| [ ]  Check application is complete and correct[ ]  Create paper and electronic files and save documents[ ]  Add applicant details to Credentialing Database |
| **Primary Decision Maker Decision** | **To be completed by Primary Decision Maker:** |
| Date of assessment: |  |
| Application: | [ ]  Approved [ ]  Limited Scope [ ]  Rejected |
| Reasons for limited scope or rejection: |  |
| Review date |  |
| Signature: | Date: |
| **Primary Decision Maker Office** | [ ]  Outcome letter sent to applicant[ ]  Copy of outcome letter sent to professional manager [ ]  Copy of outcome letter attached to application[ ]  Approval details added to Credentialing Database |