dental health
services victoria
oral health for better health

Application for Credentialing and approval of Scope of Clinical Practice

This form sets a minimum information standard and while information can be added, information requirements are not to be deleted. Please note: If you need to correct any error in your application, please initial the correction.

New Application

Renewal

Amended Scope of Practice

OTC Program

Royal Flying Doctors Program

Melbourne Dental School

Melbourne Dental School CPD

Royal Melbourne Institute Technology

If you need any further information on completing the application please contact

Ms Maria Broumos on 9341 1126

Once the application is completed and you and your manager have signed the application, please send to:

Ms M Broumos

Credentialing and Scope of Clinical Practice Coordinator

720 Swanston Street

Carlton 3000

1. Applicant and contact details

Surname	
Given Name/s	
Previous/Other Name Please include your previous name if that appears on certificates	
Date of Birth	
Residency status Australian citizen/permanent/temporary resident)	
Postal Address	

	Postcode
Phone	
Mobile	
E-mail address	

***** For New Applications - Please attach a copy of your full CV to this application

2. Application for scope of clinical practice

☐ **Group 1:** **Dental Practitioner**	☐ General Dentistry ☐ Dental Therapy ☐ Dental Hygiene **<u>Dental Prosthetics</u>** ☐ Full Dentures, Partial dentures and mouthguards ☐ Full Dentures and mouthguards only Able to construct implant retained over-dentures
☐ **Group 2:** **Specialist Dentist** **Must have specialist registration)**	☐ Endodontics ☐ Prosthodontics* ☐ Periodontics* ☐ Orthodontics ☐ Oral Medicine ☐ Paediatric Dentistry ☐ Special Needs Dentistry Public Health Dentistry ☐ Dento-Maxillofacial Radiography ☐ Oral & Maxillofacial Surgery* ** including surgical / prosthetic placement of implants*

☐ **Group 3:** **Allied Health Professional**	☐ Physiotherapy ☐ Medical Imaging Technology – Dental Radiography ☐ Dental Assistant- Licensed to take Intra Oral Radiographs Only ☐ Dental Assistant- Oral Health Educator <u>Anaesthetist</u> ☐ Public Patients ☐ Private Patients <u>Registered Nurse</u> ☐ Division 1 ☐ Medication Endorsed ☐ Iv Endorsed ☐ Infection Control Clinical Nurse Consultant ☐ Immunisation Nurse ☐ HIV/HBV Counsellor ☐ Prescribed Blood Collection Person
☐ **Group 4:** **Relative Analgesia using Nitrous Oxide and Oxygen)**	***Please attach evidence of course completion of Relative Analgesia using Nitrous Oxide and Oxygen) training within last 24 months***

☐ **Group 5** **Postgraduate Clinical Teacher** **MDS**	☐ Dento – Maxillofacial Radiography ☐ Endodontics ☐ Dental Implants ☐ Prosthodontics* ☐ Dental Prosthetics ☐ Periodontics* ☐ Orthodontics ☐ Oral Medicine ☐ Paediatric Dentistry ☐ Special Needs Dentistry ☐ Oral & Maxillofacial Surgery* ☐ * including surgical/prosthetic placement of implants
☐ **Group 6** **Undergraduate Clinical Teacher** **MDS** **DHSV** **RMIT**	☐ General Dentistry ☐ Dental Radiography ☐ Endodontics ☐ Dental Implants ☐ Prosthodontics* ☐ Periodontics* ☐ Orthodontics ☐ Oral Medicine ☐ Paediatric Dentistry ☐ Special Needs Dentistry ☐ Dental Hygiene ☐ Dental Therapy ☐ Dental Prosthetics ☐ Oral & Maxillofacial Surgery* ☐ including surgical/prosthetic placement of implants
☐ **Group 7** **Clinical Teacher with restricted scope**	Registration Limited to ☐ Endodontics ☐ Dental Implants ☐ Prosthodontics* ☐ Periodontics* ☐ Orthodontics ☐ Oral Medicine ☐ Paediatric Dentistry ☐ Special Needs Dentistry ☐ Dental Hygiene ☐ Dental Therapy

	☐ Dental Prosthetics ☐ Oral & Maxillofacial Surgery* ☐ including surgical/prosthetic placement of implants
☐ **Group 8** **Specialist in Training** **DHSV** **MDS**	☐ Dento – Maxillofacial Radiography ☐ Endodontics ☐ Dental Implants ☐ Prosthodontics* ☐ Dental Prosthetics ☐ Periodontics* ☐ Orthodontics ☐ Oral Medicine ☐ Paediatric Dentistry ☐ Special Needs Dentistry ☐ Oral & Maxillofacial Surgery* ☐ * including surgical/prosthetic placement of implants
☐ **Group 9** **Undertaking RACDS Training and Practice**	☐ Oral & Maxillofacial Surgery* ☐ * including surgical/prosthetic placement of implants
☐ **Group 10** **Intern Program** **DHSV appointed**	☐ General Dentistry – DHSV Intern Scope of Practice granted for duration of the program
☐ **Group 11:** **Undertaking OTC training**	Course start date: Course completion Date:
☐ **Group 12:** **Undertaking CPD training**	Course Title: Course start date: Course completion Date: Course Provider:
☐ **Group 13:** **The Royal Flying Doctor Service or Mobile dental care**	☐ General Dentistry

3. Regulatory Matters

Australian Health Practitioner Regulation Agency (AHPRA) Registration Is this registration limited? If yes, provide details. Attach a copy of current Registration Certificate	Registration No: _____ Yes ☐ No ☐
If you have a limited registration and/or you are to be supervised, please provide details including name and location of supervisor and frequency of supervision).	
Do you have any conditions or restrictions placed on your registration either in Australia or overseas? If so, please provide dates and particulars on separate attachment.	Yes ☐ No ☐
In the past have you ever had any conditions or restrictions placed on your registration either in Australia or overseas? If so, please provide dates and particulars on separate attachment.	Yes ☐ No ☐
Have you ever been the subject of disciplinary decision/ruling in the course of your work as a Practitioner?	Yes ☐ No ☐
If YES, please describe.	
Have you ever been the subject of a disciplinary decision/ruling or professional sanctions imposed by any registration board whether in Australia or overseas?	Yes ☐ No ☐
Radiation Use Licence The licence is required by any clinical demonstrator who will be overseeing the taking of radiographs by the student. Attached copy of current certificate, if you are requesting a scope of clinical practice in: • General Dentistry • Dental Therapy • Endodontics • Paediatric dentistry • Dento Maxillofacial Radiography • Special Needs Dentistry • Or any clinical teaching in any of the above	Licence No: Expiry Date_____ _____
Scope of Clinical Practice Have you ever been denied a defined scope of clinical practice?	Yes ☐ No ☐

Has your right to practise ever been withdrawn, suspended, terminated or reduced?	Yes ☐ No ☐
If you have answered YES to either of the above questions, please provide dates and particulars on a separate attachment.	
Do you have a Current Victorian Working With Children's Check Card? Please note that if you are undertaking paid employment you are required under the WWCC Act to have a Working with Children's Check Card	Yes ☐ No ☐ Card Number _____ Expiry Date_____

4 Health Status

Do you have a disability/health issue that: • may have an impact on your ability to perform any of the cognitive and physical functions which would fall within the scope of practice that you are seeking in this application? • may require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application?, • may be relevant to determining your scope of practice? In answering this question, please have regard to APHRA publications (available at www.ahpra.gov.au This information can be provided on this form or, if you prefer, you can provide the information in a sealed envelope marked '*confidential only for Chair, Credentialing and Scope of Clinical Practice Committee*' appended to this application, and indicate here that additional information is provided separately in this manner. This information is sought to enable an assessment to be made as to whether you can safely perform the inherent/reasonable requirements of the work which you seeking to perform at the hospital/clinic by submitting this application, or whether any reasonable adjustments might be required to ensure that you can work at the hospital/clinic in a way that ensures patient safety.	Yes ☐ No ☐

5 Indemnity Information

Current dental indemnity cover only required for rights to private practice Attach a certified copy of current policy renewal certificate	Policy No: ---------- Exp date: ----------
Is your proposed scope of clinical practice reflected in or covered by your current dental indemnity insurance?	Yes ☐ No ☐
Have there ever been or are there currently pending any claims, settlements or judgments against you?	Yes ☐ No ☐
Has your current or any previous dental insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage?	Yes ☐ No ☐
If the answer to any of the above is YES, please provide a detailed explanation and specify the name of the relevant dental insurer on separate attachment.	

6. Referees not applicable to postgraduate students, amended scope of practice, Research, CPD Participants or renewals)

Provide details of two independent professional referees who have been in a position to judge your qualifications and experience during the past five years and who have no conflict of interest in providing a reference.

Referee 1

Name	
Position held currently	
Professional address	Postcode
Phone BH	
Phone Mobile	
Fax	
e-mail address	

Referee 2

Name	
Position held currently	
Professional address	Postcode
Phone BH	
Phone Mobile	
Fax	
e-mail address	

If you require further space to answer any questions, please attach separate pages, identified with the relevant section number.

12. Agreement/Undertakings

12.1 I understand that in assessing my application, DHSV will make additional enquiries as to my suitability for the position	Yes ☐ No ☐

12.2 I understand that DHSV will conduct a routine criminal history check in relation to my current and previous place of residence.	Yes ☐ No ☐
12.3 I authorise DHSV to obtain information relevant to my application from the Dental Board of Australia and any other board regulating health practitioners, whether in Australia or overseas.	Yes ☐ No ☐
12.4 I authorise DHSV to obtain information relevant to my application from my current and any previous dental insurer, where rights to private practice apply.	Yes ☐ No ☐
12.5 I authorise DHSV to obtain information relevant to my supervision requirements where applicable.	Yes ☐ No ☐
12.6 I authorise DHSV to seek information as to my past experience, performance and current fitness to practice from my referees and from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation.	Yes ☐ No ☐
12.7 I authorise access to the above information by representatives of DHSV's Credentialing and Scope of Clinical Practice Committee and sub-committee.	Yes ☐ No ☐
12.8 If my scope of practice is approved, I agree to familiarise myself with relevant DHSV policies and procedures and to abide by them.	Yes ☐ No ☐
12.9 If my scope of practice is approved, I agree to abide by the Federal and State Privacy Legislation and National Privacy Principles and understand that breaches may result in the cessation of my appointment.	Yes ☐ No ☐
12.10 I agree to notify the Executive Director, RDHM or his/her delegate of any event/situation which may have an impact on my ability to exercise my scope of clinical practice, whether it be due to dental registration matters, or otherwise. This includes matters about which I consider that the Executive Director, RDHM or his/her delegate would wish to be informed and, as a minimum, includes the kinds of information covered in this application such as any criminal charges or convictions, reductions in registration or insurance.	Yes ☐ No ☐
12.11 If appointed, I agree to comply with relevant ongoing dental educational/certification programs and to furnish details to the health service on an annual basis as requested by the Executive Director, RDHM or his/her delegate.	Yes ☐ No ☐
12.12 (Not applicable to postgraduate students) If my scope of practice is approved, I agree to participate in DHSV's performance appraisal process.	Yes ☐ No ☐
12.13 I agree to promptly notify the Executive Director, RDHM or his/her delegate of any adverse clinical incident I am involved in or of which I become aware.	Yes ☐ No ☐

12.14 If my scope of practice is approved, I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.	Yes ☐ No ☐
12.15 If my scope of practice is approved, should any question as to my credentialing or clinical practise arise, I agree that DHSV may make such enquiries as it considers necessary to assess whether that credentialing or my scope of clinical practice is appropriate.	Yes ☐ No ☐

Applicant Check List

Current contact details	Yes ☐
APHRA registration number	Yes ☐
Radiation licence number if applicable	Yes ☐
Dental Indemnity insurance details if applicable	Yes ☐
Working with Children licence number	Yes ☐
Two referees if applicable	Yes ☐
Has the applicant signed below	Yes ☐
Has the manager signed below	Yes ☐

Declaration

I hereby declare that the information contained in this application is true and correct.

Signature of Applicant: _____Date:_____

If, for any reason, you are unable to sign the declaration above, please explain the circumstances.

Name of Manager / Course Convenor/ Course Coordinator:_____

Please Print

Signature of Manager: _____Date: _____

Managers Declaration

As part of the credentialing process two relevant clinical references have been obtained

Yes ☐ No ☐

Signature of Manager: _____Date:_____

Applicants please note: The information collected on this form will be used by the DHSV Credentials and Scope of Clinical Practice Committee to assist in the determination of your application. Information provided on this form will not be used or disclosed for any other purpose. Applications endorsed by the Committee may be copied and forwarded to relevant Clinical Managers for determining the timing of future individual credentialing and clinical privilege reviews.

DHSV operates in accordance with Federal and State Privacy Legislation including adherence to the National Privacy Principles. Copies of DHSV Privacy and Confidentiality Policies are available upon request.

Reviewed by DHSV Credentials and Scope of Clinical Practice Committee

Date Submitted to the Credentialing and Scope of Clinical Practice Committee

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☐ Approved

☐ Approved with the Following Conditions

_____-
_____
_____

Rejected for the following reasons

_____
_____
_____

Signature_____

Chair Credentialing and Scope of Practice Committee

Date Approved_____