Melbourne Dental Clinic

Prepared: May 2014
Version 5
For Review: May 2017
Responsibility: Human Resources

CREDENTIALING APPLICATION FORM

1. Applicant and contact details

Last Name	
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** **Oral Health Practitioner**	☐ General Dentistry ☐ Dental Therapy ☐ Dental Hygienist ☐ Dental Prosthetics ☐ Able to work on full Dentures, Partial dentures and mouthguards ☐ Able to work on full Dentures and mouthguards only

☐ **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**	☐ Medical Imaging Technology- Dental Radiography ☐ Dental Assistant -Licensed to take Intra Oral Radiographs only ☐ Dental Assistant –Oral Health Educator
☐ **Group 4** **Relative Analgesia using** **Nitrous Oxide & Oxygen**	Please attach evidence of completion of relative Analgesia using Nitrous Oxide and Oxygen training within last 24 months
☐ **Group 5** **Postgraduate** **Clinical Teacher**	☐ 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 (BOH) and DDS Clinical Teacher**	☐ 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** **Specialist in Training**	☐ 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

3. Regulatory Matters

Australian Health Practitioner Regulatory Agency Registration Is this registration specific? If yes, provide details. Attach a certified copy of current Registration Certificate	Registration No: ---------- Yes ☐ No☐
If you have a specific 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 Victoria or elsewhere)? 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 Victoria or elsewhere)? 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 an Oral Health 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 Victoria or elsewhere?	Yes☐ No☐
Radiation Use Licence (Attach certified copy of current certificate) Attach certified copy of current certificate if you request scope of clinical practice in: • General Dentistry • Dental Therapy • Endodontics • Prosthodontics • Periodontics • Paediatric dentistry • Dento Maxillofacial Radiography • Special needs Dentistry • Or any clinical teaching in any of the above scopes- where evidence of their irradiation user licence must be provided. **Please note**: A Radiation Use Licence is required by any clinical supervisor who will be overseeing the taking of radiographs by students.	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? As part of your clinical placement at MDC, you will be required to possess a current Victorian **Employee** (not Volunteer) 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.com.au This information can be provided on this form or, if you prefer, you can provide the information in a sealed envelope marked 'confidential for clinical director only' 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 for New Applicants

(not applicable to postgraduate students, altered 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.

7. Agreement/Undertakings

7.1 I understand that in assessing my application, MDC will make additional enquiries as to my suitability for the position.	Yes☐ No ☐
7.2 I will provide a current national Police Check	Yes ☐ No ☐
7.3 I authorise MDC to obtain information relevant to my application from any board regulating health practitioners, whether in Victoria or elsewhere.	Yes☐ No ☐
7.4 I authorise MDC to obtain information relevant to my application from my current and any previous dental insurer. (Where rights to private practice apply)	Yes☐ No ☐
7.5 I authorise MDC to obtain information relevant to my supervision requirements (where applicable).	Yes☐ No ☐
7.6 I authorise MDC 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 ☐
7.7 I authorise access to the above information by representatives of the MDC/MDS Credentialing Committees.	Yes☐ No ☐
7.8 If my scope of practice is approved, I agree to familiarise myself with MDC/MDS policies and procedures and to abide by them.	Yes☐ No ☐
7.9 If my scope of practice is approved, I agree to abide by the organisations' and state and national privacy laws and policies and understand that breaches may result in the cessation of my appointment.	Yes☐ No ☐
7.10 I agree to notify the MDC CEO 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 Head of Dental Services MDC, CEO or his/her delegate, or Clinical Governor, 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 ☐
7.11 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 MDC	Yes☐ No ☐
7.12 (not applicable to postgraduate students) If my scope of practice is approved, I agree to participate in MDC/MDS clinical supervision and performance appraisal process if required.	Yes☐ No ☐
7.13 I agree to promptly notify the MDC CEO or their delegate of any adverse clinical incident I am involved in or of which I become aware.	Yes☐ No ☐

7.14 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 ☐
7.15 If my scope of practice is approved, should any question as to my credentialling or clinical practice arise, I agree that the MDC credentialing committee may make such enquiries, as it considers necessary to assess whether that credentialling or my scope of clinical practice is appropriate.	Yes☐ No ☐

Applicants Check List

Current contact details	Yes ☐
APHRA registration number	Yes ☐
Radiation licence number (if applicable)	Yes ☐
Dental Indemnity insurance details (if applicable)	Yes ☐
Victorian Working with Children's Check Card (Employee type)	Yes ☐
Two referees (if applicable)	Yes ☐
Has the Applicant Signed Below	Yes ☐
Has the Clinical Governor 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.

Clinical Governor's Declaration

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

Yes ☐ No ☐

Name of Clinical Governor/ Course Convenor/ Course Coordinator:

_____

Please Print

Signature of Clinical Governor: _____Date: _____

CEO Declaration

Signature of CEO: _____Date: _____

Applicants please note: The information collected on this form will be used by the MDC Credentialing 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 Governors for determining the timing of future individual credentialing and clinical privilege reviews.

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

Reviewed by MDC Credentialing Committee

Date Submitted to the Credentialing and Scope of Clinical Practice Committee ----/-----/-------

☐ Approved

☐ Approved with the Following Conditions_____-

_____

_____

_____

Rejected for the Following Reasons

_____

_____

_____

Signature_____Date Approved_____

Chair Credentialing Committee

Applicant name:

Item	Checked/comments
1. Proof of identification	
2. Contact details provided	
3. Provider number	
4. Prescriber number	
5. Qualifications	
6. Training and experience (if required)**	
7. Clinical appointments (if required)**	
8. Dental registration	

9. Dental indemnity cover currency	
10. Academic appointments/teaching experience	
11. Continuing professional development	
12. Grand rounds (if applicable)	
13. Health status	
14. Referees (if required)**	
15. Existing contract/employment arrangements checked and relevant documentation available (if required)**	
16. Declaration signed	
17. Victorian Working with Children's Check Card (Employee Type)	
*** Not required for reappointment at same health service with no change in scope of practice.*	
18. Other comments:	

Application details checked by :

Signature:	Date:

Letter to applicant advising outcome of application Yes ☐ Copy attached ☐