Application for Re-accreditation

Allied Health Professional

Epworth

Contact Details

Name: DOB: / /

Company Name: (if applicable) ABN:

Address: *(Home)* Phone: (Home)

Address: (Business) Phone: (Business)

Email: Mobile:

Professional Details

Profession:

Anticipated scope of practice: (e.g. speech pathology, pain management, hand therapy etc.)

Qualification(s) relevant to application: Please specify

In case of emergency Name: Phone:

Attachment Required *(please check when submitted)*

- ◯ Copy of current professional registration (if applicable)
- ◯ Certified copy of Professional Indemnity & Public Liability Insurance.
- ◯ Copy of annual Basic Life Support (BLS) assessment and training certificate
- ◯ Copy of annual Hand Hygiene Australia on-line learning package certificate
- ◯ Current fee schedule
- ◯ Copy of current equipment electrical safety check (if applicable)
- ◯ Valid Working with Children's Check

a) I hereby apply to be re-accredited at Epworth HealthCare to carry out the ordinarily expected duties and responsibilities of a (profession) _____, for which I am qualified and eligible to practice in the State of Victoria.

b) I accept accreditation to take part in the total care of any patient at Epworth HealthCare following a doctor's referral, and I also accept the need for the maintenance of the highest standards of patient care, including the maintenance of Epworth's medical records, and participation in relevant Professional Development Activities.

c) For inpatients I understand that I am required to ensure the Nursing Unit Manager (NUM)/Associated Nursing Unit Manager (ANUM) is aware of the service provided and allocation of costs are confirmed

d) I accept that I should not represent myself as part of Epworth or use Epworth letterhead or Epworth name to promote my business

e) I agree to be familiar with and follow Epworth HealthCare policy and protocols relating to emergency management and infection control

f) I have read and hereby agree to the requirements of the *Epworth Allied Health Credentialing Guide*.

g) I agree to annually submit copies of current professional registration (if applicable), Professional indemnity & Public Liability Insurance, BLS and Hand hygiene certificates

Signed

Signature: Date : / /

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