# Application for credentialing and defined scope of clinical practice

**Allied Health professionals working in Torres and Cape Hospital and Health Service (TCHHS), but not employed by TCHHS - or - TCHHS employees requesting extended scope of practice (complex cases)**

| Type of application (select one and provide details as required) | | | |
|---|---|---|---|
| New application | Renewal | Mutual recognition | Change of scope |
| Complex cases - details: | | | |

| Allied Health Profession | | | |
|---|---|---|---|
| Audiology | Audiometry | Dietetics/Nutrition | Exercise Physiology |
| Occupational Therapy | Optometry | Pharmacy | Physiotherapy |
| Podiatry | Psychology | Radiography | Social Work |
| Sonography | Speech Pathology | Other: | |

| Personal details | |
|---|---|
| **Given name/s:** | |
| **Last name:** | **Previous name:** |
| (Please include your previous name if that appears on certificates and provide evidence of reason of name change) | |
| **Date of birth:** | **Gender:** Female Male |

| Contact details | | |
|---|---|---|
| **Home address:**<br>Preferred address for correspondence | **Practice address:**<br>Preferred address for correspondence | |
| **Phone:** | **Mobile:** | **Alt mobile:** |
| **Email (1):** | | |
| **Email (2):** | | |
| **Emergency contact name:** | | **Mobile:** |

| Registration to practice in Australia | |
|---|---|
| AHPRA - registration # | ASAR- registration # |
| Other registration body: | Registration # |

| Professional membership/s | |
|---|---|
| Organisation/Association: | Membership # |
| Organisation/Association: | Membership # |

| Clients you will be working with | | |
|---|---|---|
| Children | Aged Care Facility | Not with children and not in an aged care facility |

| Clinical areas you intend to practice |
|---|
| |

| Service, location and frequency of visits | | |
|---|---|---|
| All TCHHS locations | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Professional qualifications | | |
|---|---|---|
| **Qualification** | **University/College/Organisation** | **Year obtained** |
| | | |
| | | |
| | | |
| Please refer to CV for additional qualifications | | |

| Continuing professional development in the past three years | | |
|---|---|---|
| **Date completed** | **Description / Name** | **Relevant to the following practice areas** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**No** – please explain

| |
|---|
| |

| Professional support |
|---|
| Name of professional supervisor / mentor: |
| Frequency of supervision / mentoring: |

| History of employment in the past three years | | |
|---|---|---|
| **Date (From / To)** | **Position title & organisation** | **Clinical practice areas** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Please refer to CV for additional employment details | | |

## References

Please nominate a **minimum of two** professional peer referees, with no conflict of interest, who can attest to your clinical skills and professional performance **within the past 12 months** in the areas for which you have applied for SoCP.

| **Referee 1**<br>**Must be current line manager/ supervisor** | **Name:** | |
|---|---|---|
| | **Position:** | |
| | **Address:** | |
| | **Ph (work):** | **Mobile:** |
| | **Email:** | |

| **Referee 2** | **Name:** | |
|---|---|---|
| | **Position:** | |
| | **Address:** | |
| | **Ph (work):** | **Mobile:** |
| | **Email:** | |

| **Referee 3** | **Name:** | |
|---|---|---|
| | **Position:** | |
| | **Address:** | |
| | **Ph (work):** | **Mobile:** |
| | **Email:** | |

## Applicant's declaration and authorisation

| I declare that all the following statements are True or False as indicated: | True | False |
|---|---|---|
| My right to practice 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 responded 'False' to any of the above questions, please attach a statement with details, dates and include any relevant documentation.** | | |
| **Details:** | | |

I, …………………………………………… will provide Queensland Health with evidence of currency of registration (if applicable), continuing professional development, membership of professional bodies and indemnity insurance on an annual basis.

I authorise Queensland Health to conduct a criminal history check and aged care or working with young children check (if required).

I am prepared to participate in 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 abide by Queensland Health policies and regulations and any terms and conditions which are attached to my appointment by the credentialing and scope of clinical practice committee. I undertake to immediately notify the Chair of the credentialing and scope of practice committee if my clinical privileges are retracted, withdrawn or altered at any other hospital or day procedure centre. I authorise Queensland Health, its officers and agents to seek information as to my experience,

**I declare that the facts and my response to this Application are accurate at time of application.**

I fully understand that providing false information or documents may result in my SoCP not being granted and may further result in my being subject to criminal charges and/or disciplinary action.

| Print applicant name: | Print witness name: |
|---|---|
| Applicant signature: | Witness signature: |
| Date: | Date: |

## Documentation required

**Copies* of the following will need to be attached to the application:**

Certificate of AHPRA registration (if from an AHPRA registered profession)
Membership of a national professional association
Current CV - signed, dated and certified by yourself as true and correct
Qualifications (certified copy*)
Certificate of accreditation with professional association - or twelve-month professional development history
Two (2) references
Drivers licence or Passport (certified copy*)
Two other forms of ID (certified copy*)
Evidence of immunisation record (VPD)
Current National Police Certificate (Name Only) (certified copy*)
**Must be issued by State/Territory police department, or the Australian Federal Police** - Cannot be a criminal check issued by a third party/private company
Current Queensland Blue Card if not from a registered professional group (certified copy*)
Updated professional indemnity insurance (including provider number and type of cover)

***copies must be certified** by a Justice of the Peace, Notary Public, Commissioner for Declarations, Solicitor or Barrister - unless your originals are sighted by the Queensland Health delegate who approves credentialing

TCHHS office use only:

**To be completed by Profession / Discipline Specific Lead:**

I recommend that this application for credentialing is supported/ not supported. (Discipline leader)

- Applicant possesses appropriate qualification/ practicing licenses
- Registration Board/ Professional Association or Council details checked
- Demonstrates continuing professional development consistent with professional requirements
- Referee contacted & report reviewed (Optional)
- Applicant interviewed (Optional)

Discipline Lead recommendation/comments:

Name:

Signature: Date:

**To be completed by TCHHS Allied Health Professional Lead (MPHS Hubs - TI, Cooktown, Weipa)**

Date of decision: Pending:

Application: Approved Limited scope Not approved

Allied Health Professional Lead Comments:

Name:

Signature: Date:

Review date (if applicable):

**Endorsed by Executive Director Allied Health**

Name:

Signature: Date: