APPLICATION FOR RE-CREDENTIALING AT ALBANY COMMUNITY HOSPICE

1. PERSONAL DETAILS

Family Name				
Given Names		**Preferred Name**		
Professional Address				
Postal Address *(if different from above)*				
PHONE	**Work**		**Mobile**	
Email				
Albany Community Hospice Provider Number				

2. SCOPE OF PRACTICE

I seek re-credentialing and Scope of Practice as follows:

☐ Specialist - General Practitioner ☐ Specialist – Other ***Speciality:*** _____

3. APPLICANT DECLARATION

I fully understand that any untrue statements in, or omissions from, this application constitute cause for denial of privileges or cause for termination of my contract. I agree to abide by the policies and guidelines applicable to Albany Community Hospice, to which I am applying for Scope of Practice.

I declare that all of the information provided is true and correct, and I agree to comply with the conditions attached to this application for Re-Credentialing and Scope of Practice.

I consent to Albany Community Hospice, obtaining relevant information on past performance or any conditions placed on my practice, including the nature of any unresolved complaints.

Name: _____

Signature: _____ **Date:** _____

4. REQUIRED DOCUMENTS CHECKLIST

Please ensure you have completed and attached the following documents to your application:

Forms to be completed
☐ Credentialing Application Form (*this form)*
☐ Expression Of Interest to Provide Medical Services at Albany Community Hospice
Supporting Documentation Checklist
☐ Current Indemnity Insurance Certificate
☐ Evidence of Continuing Medical Education
☐ Police Clearance (no more than 3 years old)
☐ Hand Hygiene Online Learning Certificate https://www.hha.org.au/online-learning/complete-a-module

Please return this form to admin@albanyhospice.org,au with the relevant forms. Thank you