Department of Health
Government of Western Australia

Application Form:
Salaried Medical Officers' Indemnity

Important Information
This is the application form for the indemnity as set out in the "Terms and Conditions of the Salaried Medical Officers Indemnity". The Indemnity is a legally binding contract based on the information you have provided about your professional practice. If there is anything in this application form that you do not understand please contact the Medical Administrator (or equivalent) at your hospital or health service.

Have you previously applied for the Department of Health's Indemnity for Salaried Medical Officers? YES ☐ NO ☐

if 'yes' please state the year and hospital / health service where the application was made.

year	*hospital*

NB – Once an application has been made and accepted it is not necessary for a Salaried Medical Officer to renew the Indemnity. However, if you are renewing your employment with the WA government health system you may wish to take this opportunity to update the information provided in a previous Application.

1. Personal Details *(please print)*

Title	*Surname*	*First name*	*Other name(s) – initial(s)*

Male ☐ *Female* ☐ | *Address*

	Postcode

Mailing address (if different from above)

	Postcode

Contact *Business* ( )	*Facsimile number* ( )
Home / Mobile	*Email*

2. Medical Qualifications

Degree *(or equivalent)*	University	Year	Degree *(or equiv.)*	University	Year

3. WA Medical Board Registration Number

REGISTRATION NUMBER

4. When were you first registered in Australia as a medical practitioner?

YEAR

Are you registered elsewhere in Australia? YES ☐ NO ☐ If 'Yes' please specify State / Territory

5. Do you currently have or have you ever had restrictions placed on your registration in any country including Australia? YES ☐ NO ☐

6. Have you ever been deregistered, refused registration or suspended from practice as a medical practitioner in any country including Australia? YES ☐ NO ☐

If 'yes' to Q5 or Q6 please provide details.

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7. Are you working under a Medical Practitioner Visa (subclass 422) or a Temporary Business (Long Stay) - Standard Business Sponsorship (Subclass 457)? YES ☐ NO ☐

If 'yes', (a) please indicate your intended departure date (if known) ____ / ____ / 20____

(b) provide the dates of any previous work you have done in Australia

8. Have you ever had your employment conditions / clinical privileges / visiting rights reduced or suspended in any country and / or at any hospital / health service? YES ☐ NO ☐

if 'yes' please provide details.

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9. Are you a member of a Medical Defence Organisation or hold a professional indemnity / Insurance policy? YES ☐ NO ☐

if 'yes', please provide name of MDO/ insurer.

10. Have you ever been refused medical indemnity insurance or membership or had an application for renewal declined in any country including Australia? YES ☐ NO ☐

if 'yes' please provide details.

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11. Have you had any claims made against you in the past five years involving medical services provided to a public or private patient in any country including Australia? YES ☐ NO ☐

if 'yes' please provide details.

12. **Have you ever had or do you know of any claims, demands, suits, restrictions or other legal actions brought or threatened against you in respect to your conduct as a medical practitioner?** (*excluding any previously notified to a teaching hospital or the DoH)* YES ☐ NO ☐

if 'yes' please provide details.

13. **Are you aware of any particular circumstances that may give rise to a claim, demand, suit or legal action being brought or threatened against you now or in the future?** *(excluding any previously notified to a teaching hospital or the DoH)* YES ☐ NO ☐

if 'yes' please provide details.

14. **Have you ever been disciplined or counselled in relation to the use of alcohol or drugs?** YES ☐ NO ☐

15. **Do you or have you worked as a non-salaried medical practitioner in any metropolitan or country non-teaching hospitals / health services?** YES ☐ NO ☐

16. **Have you applied for the Department of Health's Indemnity for Non-Salaried Medical Practitioners?** YES ☐ NO ☐

if 'yes' please state the year and hospital / health service where the application was made.

year	*hospital / health service*

17. **In relation to clinical governance, clinical quality assurance, quality improvement or risk management activities in the hospital or health service, are you currently, or have within the last 12 months, participated in any such activities? -** *examples might include clinical audit, medication committee, investigation of adverse events including sentinel events-* YES ☐ NO ☐

if 'yes', please provide details.

If the space provided for details is insufficient, please attach a separate statement.

18. DECLARATION

I wish to apply for the Department of Health's "Salaried Medical Officers' Indemnity".

By signing this Application Form:

(a) I declare that to the best of my knowledge and belief the information provided in this application is true and correct and I have not withheld any relevant information.

(b) I consent to personal information provided by me to be shared between the Department of Health and RiskCover, or as required by law. I consent to the Department of Health and RiskCover also disclosing personal information to and/or collecting additional information from investigators, legal advisers, medical advisers, actuaries or other advisers whom the Department of Health or RiskCover may engage to assist in processing this proposal for indemnity and any subsequent claims.

(c) I acknowledge that I have read and understood the "Terms and Conditions of the Salaried Medical Officers' Indemnity" as available on the website at http://www.health.wa.gov.au/indemnity/ or on request.

(d) I agree to be bound by the "Terms and Conditions of the Salaried Medical Officers' Indemnity".

Please Sign And Date Here

Signature ______________________ Date ____________

Please print your name ______________________

19. OFFICE USE ONLY

Indemnity Number

An authorised officer at the hospital or health service is to complete this section.

"The Minister for Health accepts this Application Form"

Signature	Date
as delegate for the Minister for Health Full name	
Position	phone number
Name of Hospital	
Address	

IMPORTANT When the above section (19) has been completed, the hospital to copy (x 2) the application and.

(a) the original to be retained by the hospital
(b) one copy is to be sent to the medical officer for his/her personal record, and
(c) one copy is to be mailed to

Legal & Legislative Services
Department of Health
PO Box 8172
Perth Business Centre WA 6849