



Application for the  
Non-Salaried Medical Practitioners' Indemnity  
1 July 2009 – 30 June 2010

**Important Information**

This is the application for the indemnity as set out in the "Terms and Conditions of the Indemnity for Non-Salaried Medical Practitioners – effective 1 July 2009". 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 Director of Medical Services at your hospital.

<b>1. Personal Details</b> <i>(please print)</i>			
Title	Surname	First name	Other name(s) – initial(s)
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Address	
			Postcode
Mailing address (if different from above)			
			Postcode
Contact Business ( )	Facsimile number ( )		
Home / Mobile	Email		

<b>2. Medical Qualifications</b>					
Degree (or equivalent)	University	Year	Degree (or equiv.)	University	Year

3. What is your 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 on a separate sheet.*

7. Are you working under a Medical Practitioner Visa (subclass 422) or a Temporary Business (Long Stay) - Standard Business Sponsorship (Subclass 457)? If 'yes', YES  NO
- (a) please indicate your intended departure date (if known) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- (b) provide the dates of any previous work you have done in Australia

8. Are you working through a locum service? YES  NO
- If 'yes' please provide the name of the locum agency \_\_\_\_\_

9. Area of Practice (please tick relevant box)

- General Practice only
- Extended General Practice (please state extended practice procedures for which you are credentialed)
- Specialist other than Radiologist (please state Speciality)
- Radiologist (please state name of Practice)
- Other (please specify)

10. Do you provide obstetric medical services on a regular basis? YES  NO

If 'yes', do your Clinical Privileges ('Scope of Clinical Practice') specifically provide you with rights to perform Caesarean sections? YES  NO

11. Do you regularly provide antenatal / shared care with an obstetric proceduralist? YES  NO

12. Do you practice primarily in the metropolitan area? YES  NO

13. Please list the WA public hospitals where you hold current Clinical Privileges ('Scope of Clinical Practice').  
*Rural doctors having admitting rights at multiple hospitals in a region list only the one(s) where you do the majority of your work.*

14. Have you ever had your Clinical Privileges ('Scope of Clinical Practice') or visiting rights reduced or suspended in any country and / or at any hospital / health service? YES  NO

If 'yes' please provide details on a separate sheet.

15. Do you currently, or have you within the last 12 months participated in any clinical governance, clinical quality assurance, quality improvement or risk management activities (eg clinical audit, Medical Advisory Committee, medication committee, investigation of adverse events including sentinel events) if 'yes', please provide details YES  NO

---

16. Are you a member of a Medical Defence Organisation or hold a professional indemnity / insurance policy? *If 'yes', please provide name of the MDO/insurer* YES  NO

---

17. 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 on a separate sheet.*

---

18. 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 detail on a separate sheet - exclude any matters previously notified to DoH.*

---

19. 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? YES  NO

*If 'yes', on a separate sheet, please indicate what these have been and give details including when you notified your insurer about the matter and whether or not the matter has been resolved - exclude any matters previously notified to DoH*

---

20. 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? YES  NO

*If 'yes' please provide details on a separate sheet - excluding any previously notified to DoH*

---

21. Have you ever received an adverse finding in relation to prescribing, billing or any other matter by a court, tribunal or other statutory body? YES  NO

*If 'yes' please provide details on a separate sheet*

---

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

*If 'yes' please provide details, including date(s) and location(s), on a separate sheet.*

---

23. Did you apply for the Minister for Health's Medical Indemnity for NSMPs in 2008/09? YES  NO

If 'yes' please tick the Service where the application was submitted.

North Metro Area Health Service  South Metro Area Health Service  WA Country Health Services

---

see page 4

24. DECLARATION

I wish to apply for the Minister for Health's "Non-Salaried Medical Practitioners' Indemnity" (as described in the "Terms and Conditions of the Indemnity for Non-Salaried Medical Practitioners - effective 1 July 2009")

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 Minister for Health, his or her delegate/s, and RiskCover, or as required by law. I consent to the Minister for Health (or delegate/s) and RiskCover also disclosing personal information to and/or collecting additional information from investigators, legal advisers, medical advisers, actuaries or other advisers whom the Minister for Health (or delegate/s) 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 Indemnity for Non-Salaried Medical Practitioners" 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 Indemnity for Non-Salaried Medical Practitioners".

Please Sign And Date Here

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please print your name \_\_\_\_\_

25. 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
<i>as delegate for the Minister for Health</i>	
Full name	
Position	phone number
Name of Hospital	
Address	

**IMPORTANT**

When the above section (25) has been completed, the hospital to copy (x 2) the application.

- (a) the original to be retained by the hospital
- (b) one copy is to be sent to the medical practitioner 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**

12/05/2009