

PRIVATELY REFERRED NON-INPATIENT MODEL



Department of Health
Government of Western Australia

PROTOCOL REGISTRATION FORM

Protocol Applying to Medical Practitioners Participating in the Privately Referred Non-Inpatients Model

Important Information

This is the Protocol Registration Form applying to Medical Practitioners participating in the Privately Referred Non-Inpatient Model. If there is anything in this form that you do not understand please contact the Director of Medical Services or equivalent at the relevant hospital or health service.

1. Personal Details *(please print)*

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

2. Medical Qualifications

<i>Degree (or equivalent)</i>	<i>University</i>	<i>Year</i>	<i>Degree (or equiv.)</i>	<i>University</i>	<i>Year</i>

3. Medicare Provider Number

4. WA Medical Board Registration Number

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

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5. Have you ever received an adverse finding in relation to prescribing, billing or any other matter by a court, tribunal or other statutory body? *If 'yes' please provide details* YES NO

6. 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

7. Are you working through a locum service? YES NO

If 'yes' please provide the name of the locum agency
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8. Area of Practice *(please tick relevant box)*

Specialist *(please state Speciality)*

Other *(please specify)*

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

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9. DECLARATION

I wish to register for the "Protocol Applying To Medical Practitioners Participating In The Ambulatory Surgery Initiative And/Or The Privately Referred Non-Inpatients Model" (June 2006) which I provide at:

Name of Hospital

By signing this Form:

- (a) I declare that to the best of my knowledge and belief the information I have provided is true and correct and I have not withheld any relevant information.
- (b) I consent to personal information provided by me to be shared by the Department of Health, or as required by law. I consent to the Department of Health 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 may engage to assist in processing this proposal for the Protocol and any subsequent claims.
- (c) I agree to comply with the Business Rules applying to the Privately Referred Non-Inpatient Model (as varied from time to time).

Please Sign And Date Here

Signature

Date

Please print your name _____

10. OFFICE USE ONLY

Number

An authorised officer is to complete this section.

I confirm the above medical practitioner is eligible to register for the Protocol applying to Medical Practitioners participating in the Privately Referred Non-Inpatient Model

Signature	Date
Full name	
Position	phone number
Name of Hospital	
Address	

- 11. When the hospital has completed the above section (10) please fax this form to Legal & Legislative Services, Department of Health – (08) 9222 4355