Appendix 4. Application/re-credentialling/change of scope of practice form – dentists

<Insert health service name>

Dentists with independent responsibility for patient care

This form sets a minimum information standard. Information may be added, but not deleted.

Surname

First name   Middle name

Please note: If you need to correct any error in your application, please initial the correction.

This is a:

New application   Renewal/re-credentialling   Altered scope of practice

1. Application for scope of clinical practice

I wish to apply to undertake a scope of practice for

(for example, oral health practitioner, specialist dentist).

The health service must verify registration, which can be accessed on the Dental Board of Australia website at <www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx>.

Please attach the following to this form:

All applications/re-credentialling

- A copy of your current professional indemnity insurance certificate (if applicable)
- Copies of relevant visa documents (if applicable)
- A copy of Radiation Use Licence (if applicable)

New appointments only

- Current curriculum vitae
- Certified copies of all specialist or other qualifications, other than a primary dental degree, if not listed on the Dental Board of Australia
- Proof of identification - 100 point check

2. Applicant contact details

Surname

Given name(s)

Previous name(s)

Date of birth

Place of birth

Residency status

(only applicable for re-credentialling/altered scope of practice if changed since last application at this health service)

Australian citizen

Permanent resident

Temporary resident

Professional address

Postcode

Postal address *(if different to professional address above)*

Postcode

Phone (BH)

Phone (AH)

Fax

Mobile/pager

Email address

Do you have a Medicare provider number for this location?

If NO, please note that you will be required to obtain one. The organisation can assist.

If YES, is it subject to any restrictions?

If restrictions apply, please provide full details.

Yes

No

Site(s):

Provider number(s):

Yes

No

Do you have a prescriber number?

Yes No

Prescriber number:

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3. All qualifications, including your basic dental degree

New appointments only – please provide certified copies of qualifications obtained.

Re-credentialling (or if applying to extend current scope of practice) – please provide certified copies of new qualifications obtained.

Qualifications	University/organisation	Year obtained
Primary dental degree		
Others		
Re-credentialling only	Are you requesting a change to your existing scope of practice? • If YES, please go to section 4. • If NO, please go to section 5.	Yes No

4. Application for scope of clinical practice – new applicants and change of scope of practice only

I wish to apply to define my scope of clinical practice to undertake the following.
(Tick all relevant boxes.)

Group 1 Oral health practitioner	General dentistry Dental therapy Dental hygiene Dental prosthetics
Group 2 Specialist dentistry	Dento-maxillofacial radiology Endodontics Oral and maxillofacial surgery* Oral medicine Oral surgery Orthodontics Paediatric dentistry Periodontics* Prosthodontics* Special needs dentistry * including surgical/prosthetic placement of implants
Group 3 Allied health professional	Physiotherapy Medical imaging technology – dental radiography
Group 4 Relative analgesia (using nitrous oxide and oxygen)	Please attach evidence of completion of relative analgesia training within the past 24 months.
Group 5 Conscious sedation	Please attach evidence of appropriate training – the minimum standard for endorsement would be a graduate diploma in conscious sedation from the Westmead Hospital or University of Sydney, or training from an alternative institution acceptable to the Dental Board of Australia.
Group 6 Private practice rights	Refer to <insert health service name> policies and procedures for particular instructions.

5. Clinical appointments

- New applications, or
- Application for a change in your scope of practice – please specify information relevant to change only

If relevant, please provide details on all current and previous clinical appointments held within the past five years (including names of organisations and dates of appointment), or other places of practice (for example, private practice).

Organisation	Name and type of appointment	Term of appointment
		to
		to
		to
		to
		to
		to
		to

6. Dental registration matters

Please refer to <www.dentalboard.gov.au> for definitions.

What is your Dental Board of Australia registration number?	
Is this *general* registration?	Yes No
Is this *specialist* registration?	Yes No If YES, please specify.
Is this *limited* registration?	Yes No

If you have a limited registration, and/or you are to be supervised, please provide details (including name and location of supervisor and frequency of supervision).	
Do you currently have any conditions, restrictions, undertakings, reprimands or notations placed on your registration or your clinical practice (either in Australia or any other country)?	Yes No
In the past, have you ever had any conditions, restrictions, undertakings, reprimands or notations placed on your registration (either in Australia or elsewhere)?	Yes No
Have you ever been the subject of a disciplinary decision/ruling in the course of your work as an oral health practitioner?	Yes No
Have you ever been the subject of a prior disciplinary decision/ruling or professional sanction imposed by any registration board, whether in Australia or elsewhere?	Yes No
Have you ever been denied a defined scope of clinical practice?	Yes No
Has your right to practise ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body?	Yes No
Have you ever been convicted or found guilty of any criminal offence, including a drug- or alcohol-related offence?	Yes No
Are you the subject of pending criminal charges?	Yes No
If you answered YES to any of the above, please provide full details or, if you prefer, provide the information in a sealed envelope marked 'Confidential for director of medical services or equivalent only' appended to this application, and indicate here that additional information is provided separately in this manner.	

<table>
<tr><td>Are you registered as a dental practitioner in any other country?</td><td>Yes No
If YES, please specify.</td></tr>
<tr><td>Do you have a Radiation Use Licence? (if applicable)
Please attach a photocopy of your current licence
Licence required for those requesting scope of practice in:
General dentistry
Dental therapy
Endodontics
Paediatric dentistry
Dento Maxillofacial radiography
Special needs dentistry</td><td>Yes No NA
Licence number:
____
Expiry date:</td></tr>
<tr><td>Do you have a current working with children check? - see website*
Please attach a photocopy of your current card.</td><td>Yes No NA
Card number:
____
Expiry date:</td></tr>
</table>

*Working with children information can be found at <www.justice.vic.gov.au/wps/wcm/connect/justlib/Working+With+Children/Home>.

7. Indemnity information

Current dental indemnity cover (if applicable)* *Essential for rights to private practice. *Please attach a copy of your current policy renewal certificate.*	Name of insurer: Policy number: Expiry date:
Is your proposed scope of clinical practice reflected in, or covered by, your current dental indemnity insurance?	Yes No
Has there ever been or are there currently pending any claims, settlements or judgements against you?	Yes No
Has your current or any previous dental insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage?	Yes No
If the answer to any of the above is YES, please provide a detailed explanation and specify the name of the relevant dental insurer on a separate attachment.	

8. Academic appointments/teaching experience

If relevant, please provide details of current and previous teaching appointments held within the past five years (including the organisation and dates of appointment).

Organisation	Status/level	Term of appointment
		to
		to
		to
		to
		to
		to
		to

9. Continuing professional development

Have you met the continuing professional development requirements of the Dental Board of Australia?	Yes No

Please provide evidence of relevant continuing professional development.

10. Quality activities (for example, participation in peer review or clinical audit activities)

For dentists undergoing re-credentialling these activities should be recorded through the *Partnering for performance* process, for example, participation in clinical review/audit/peer-review activities.

Have you participated in regular clinical reviews, audits and/or peer-review activities in any clinical setting?	Yes No
Provide details of these quality/peer review activities.	

11. Health status

<table>
<tr><td>Do you have a disability or health issue that:
• may impact on your ability to perform any of the cognitive and physical functions that would fall within the scope of practice that you are seeking in this application?
• may require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application?
• may be relevant to determining your scope of practice?</td><td>Yes No</td></tr>
<tr><td colspan="2">If you answered YES, please provide details of the disability or health issue and its likely, or possible, impact on your ability to carry out the sought scope of practice. Details of any special equipment facilities or work practices required should be included.

This information can be provided on this form or, alternately, you can provide the information in a sealed envelope marked ‘Confidential for medical director only’ appended to this application. Indicate here if additional information is being appended.

This information is sought to enable an assessment to be made as to whether you can safely perform the inherent and reasonable requirements of the work that you seek to perform at the health service or whether any reasonable adjustments might be required to ensure that you can work at the health service in a way that ensures patient safety.</td></tr>
</table>

12. Referees (new appointments only)

Please provide details of at least two referees, preferably within the specialty being applied for, who have been in a position to judge your qualifications and experience during the previous three years and who have no conflict of interest in providing a reference.

Referee 1

Name	
Current position	
Professional address	
	Postcode
Phone (BH)	Phone (mobile)
Email address	

Referee 2

Name	
Current position	
Professional address	
	Postcode
Phone (BH)	Phone (mobile)
Email address	

Referee 3

Name	
Current position	
Professional address	
	Postcode
Phone (BH)	Phone (mobile)
Email address	

13. Agreement/undertakings

I understand that in assessing my application, <the health service> will make additional enquiries as to my suitability for the position.

New applications only

I understand that the health service will conduct a police check.	Yes	No

New appointments and expanding scope of practice only

I authorise the health service to seek information as to my past experience, performance and current fitness to practise from my referees.	Yes	No
I agree to familiarise myself with relevant hospital by-laws, policies and procedures, and to abide by them.	Yes	No

All applications

I accept that the health service will obtain information relevant to my application from the Dental Board of Australia and any other authority that regulates health practitioners.	Yes	No
I authorise the health service to obtain information relevant to my application from my current and any previous dental insurer.	Yes	No
I authorise the health service to obtain information relevant to my supervision requirements (where applicable).	Yes	No
I authorise the health service to seek information from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation.	Yes	No
I agree to abide by the organisation's and state and national confidentiality and privacy laws and policies and understand that breaches may result in the cessation of my appointment.	Yes	No
I agree to notify the director of medical services or their delegate of any event/situation that may have an impact on my ability to exercise my scope of clinical practice, whether it be due to dental registration matters, or otherwise. This includes matters about which I consider that the director of medical services or their delegate would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, or reductions in registration or insurance).	Yes	No

I agree to participate in this health service's performance development and support process *(Partnering for performance* or equivalent).	Yes No
I agree to promptly notify the director of medical services or their delegate of any adverse clinical incident I am involved in, or of which I become aware.	Yes No
I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.	Yes No
Should any question as to my credentialling or clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that credentialling or my scope of clinical practice is appropriate.	Yes No

14. Declaration

I hereby declare that the information contained in this application is true and correct.

Signature of applicant	Date

Please note: if for any reason you are unable to sign the declaration above, please explain the circumstances.

Please note: The information collected on this form will be used by the <insert health service name> Credentialling and Scope of Clinical Practice Committee(s) to assist in the determination of your application. Information provided on this form will not be used or disclosed for any other purpose.

<Insert health service name> operates in accordance with federal and state privacy legislation, including adherence to the national privacy principles. Copies of <health service name> privacy and confidentiality policies are available upon request.

Health service use only

Applicant name

Item	Checked/comments()
1. Proof of identification	
2. Contact details provided	
3. Provider number	
4. Prescriber number	
5. Qualifications	
6. Training and experience (if required)**	
7. Clinical appointments (if required)**	
8. Dental registration	
9. Dental indemnity cover currency	
10. Academic appointments/teaching experience	
11. Continuing professional development	
12. Grand rounds (if applicable)	
13. Health status	
14. Referees (if required)**	
15. Existing contract/employment arrangements checked and relevant documentation available (if required)**	
16. Declaration signed	
17. Working with children certificate (if applicable)	
*** Not required for reappointment at same health service with no change in scope of practice.*	

18. Other comments:	

Application details checked by <insert name>:

Signature	Date

Letter to applicant advising outcome of application Yes Copy attached

100 points – verification details

Type of check	Available points	Notes
Passport (current or expired by less than two years, not cancelled) Citizenship certificate (Australian only) Birth certificate (original or extract) Birth card issued by the Victorian Registry of Births, Deaths and Marriages	70	Must contain name and a photo. Select one only.
Written reference Written reference from an acceptable referee from a financial institution	40	Select one only. Referee to have known the signatory for at least 12 months. Both signatory and referee must sign the reference.
Driver's licence. Renewed, interim, provisional, truck or learner's Other acceptable government-issued licences include boat, gun or pilot Public Service Employee Identification Card Pension or government Health Care Card (reference number required) Identification card issued by a tertiary education institute	40 40 40 40 40	Must contain name, expiry date, a photo or signature.
Letter from a current employer (current or must have been employed by the employer within the past two years)	35	Must be on letterhead or company seal. Both employer and employee's signature must be on the letter, along with the name and address of the employee.
Medicare card Overseas or international driver's licence or Proof of Age card	25 25	

Financial institution's credit card, cash card or passbook	25	Only one current card/passbook can be accepted from each financial institution. You may supply details from several different institutions but cannot solely rely on this form of identification.
Type of check	Available points	Notes
Rating authorities Rate notice (current). Provide the deposited plan (DP) number	35	
Public utility (water rate notice, electricity, gas or telephone account – no mobile accounts). Take a *current* notice with you.	25	
Statement from landlord, managing agent or owner of customer premises	25	Take letter, rental contract or rent receipt with you.