

SA Health Allied & Scientific Health Professional Initial Credentialing Application

This form is for use by allied and scientific health professionals (ASHPs) employed by SA Health and not previously credentialed in accordance with the *Credentialing and Defining Scope of Clinical Practice for Allied and Scientific Health Professionals Policy* (including registered, self-regulated and relevant unregulated professions).

PART 1 – APPLICANT DETAILS	
Title : _____	SA Health Employee: YES
Surname: _____	First Name: _____
Middle Name/s: _____	Previous Name/s: _____
Date of Birth: ____ / ____ / ____	
Email: _____	Phone: _____
Job Title & Profession: _____	
Clinical Service: _____	
NON-AUSTRALIAN RESIDENTS ONLY - if yes, please attach a copy to this application Do you require a Work Visa to practise in Australia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Manager Sign Off <input type="checkbox"/> N/A or <input type="checkbox"/> Attached
CURRICULUM VITAE (CV) demonstrating appropriate experience & recency of practice for the role to be undertaken <input type="checkbox"/> Attached	<input type="checkbox"/> Assessed as suitable
REQUESTED LHNS FOR CREDENTIALING <input type="checkbox"/> CALHN <input type="checkbox"/> NALHN <input type="checkbox"/> SALHN <input type="checkbox"/> WCHN <input type="checkbox"/> Regional LHNS <input type="checkbox"/> SCSS <input type="checkbox"/> DHW	

PART 2 – PROFESSION & SCOPE OF CLINICAL PRACTICE (complete section A, B or C as relevant)	
A. REGISTERED PROFESSION	Manager Sign Off
Profession: _____ Registration Number: _____ Expiry Date: ____ / ____ / ____ Registration Type: _____ Conditions: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify: _____ Do you hold AHPRA endorsement in a specific area of practice? <input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, please specify _____ Evidence of Continuing Professional Development (CPD) to the level required by your registration type: <input type="checkbox"/> Attached Do you hold any qualifications or training that permits advanced or extended scope of practice? <input type="checkbox"/> No (scope of clinical practice is Profession as listed above) <input type="checkbox"/> Yes - Advanced Scope <input type="checkbox"/> Yes - Extended Scope Please specify training/qualification and scope of practice: _____ _____ Are you required to undertake an advanced or extended scope in your current role? <input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, manager must approve for current role Are you applying for endorsement as an allied health advanced clinical practitioner? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Registration (+/- endorsement) details sighted on AHPRA website Date sighted: <input type="checkbox"/> Evidence of CPD received Scope of practice in current role: <input type="checkbox"/> Standard scope of practice (profession) OR <input type="checkbox"/> Advanced scope of practice as specified OR <input type="checkbox"/> Extended scope of practice as specified <input type="checkbox"/> Allied Health Advanced Clinical Practice Credentialing

Medical Radiation Professions Only: LSPN: _____
EPA radiation licence number: _____ Expiry Date: / /

Portfolio (if applicable)
Date sighted:
 Licence details sighted
Date sighted:

B. SELF-REGULATED PROFESSION

Manager Sign Off

Profession: _____

Original certificate or transcript of primary and/or postgraduate qualification from an accredited/ recognised university training program attached Yes

Qualification transcript or certificate sighted

Professional Association: _____

Date sighted:

Eligible for Full Membership Yes No

Eligibility for membership confirmed

Are there any restrictions or special conditions placed on your professional association membership/eligibility? Yes No

Evidence of accreditation sighted

If yes, please specify: _____

Date sighted:

Do you hold formal Accreditation? Yes No

If yes, please specify accrediting body, type/title, number & date of expiry of accreditation: _____

Evidence of participation with Continuing Professional Development (CPD) attached:

Self-managed portfolio in accordance with guidelines set by Professional Assoc

Evidence of CPD received

Accredited/formal CPD program with specified points/hours

Scope of practice in current role:

Do you hold any qualifications or training that permits advanced or extended scope of practice? No (*scope of clinical practice is Profession as listed above*)

Standard scope of practice (profession) OR

Yes - Advanced Scope – please specify training/qualification and scope:

Advanced scope of practice as specified OR

Yes - Extended Scope – please specify training/qualification and scope:

Extended scope of practice as specified

Are you required to undertake an advanced or extended scope in your current role?

No Yes (*if yes, manager must approve for current role*)

Allied Health Advanced Clinical Practice Credentialing Portfolio (if applicable)

Are you applying for endorsement as an allied health advanced clinical practitioner?

No Yes

Date sighted:

Have you ever been denied accreditation/professional association membership?

Yes No

Have any claims, investigation or malpractice lawsuits been made against you?

Yes No

Has your scope of clinical practice and/or appointment at any health service been reduced, suspended or revoked or have you had any conditions attached to your appointment for any reason?

Yes No

Do you have any other information regarding your ability to practise to declare?

Yes No

If yes to any of the above, please submit details with this application.

PART 3 - NATIONAL CRIMINAL HISTORY SCREENING	Manager sign off
<p>The type of criminal history check(s) required varies based on the nature of the work undertaken and the client type. Applicants should confirm with their line manager as to what checks are required for the role(s).</p> <p>Criminal history screening and information about these requirements is available via the SA Health Criminal and Relevant History Screening Policy.</p>	
<p><i>Complete details for all criminal history checks you hold.</i></p> <p>National Police Clearance (NPC) noting unsupervised contact with vulnerable groups</p> <p>Date of issue: / / Reference Number: _____</p> <p>DHS Criminal History Screening</p> <p>Working With Children Check (WWCC)</p> <p>Date of issue: / / Reference Number: _____</p> <p>NDIS Worker Check</p> <p>Date of issue: / / Reference Number: _____</p> <p>Vulnerable Person-Related Employment Check</p> <p>Date of issue: / / Reference Number: _____</p> <p>Aged Care Sector Employment Check</p> <p>Date of issue: / / Reference Number: _____</p> <p>General Employment Probity Check</p> <p>Date of issue: / / Reference Number: _____</p>	<p><input type="checkbox"/> Evidence sighted</p> <p>Date sighted:</p>

PART 4 – DECLARATION BY APPLICANT
<p>To the best of my knowledge, the information provided in this application is true and correct. I understand that any incorrect statement may result in refusal in granting or the withdrawal of existing credentials. I authorise my professional discipline manager or senior allied health professional to seek information relating to my credentials and experience as relevant to my application.</p> <p>I undertake to inform my employer of any complaint made about my professional conduct or of any change in registration/professional membership status.</p> <p>I understand that information given in this application will be entered into the SA Health Credentialing and Scope of Clinical Practice System (CSCPS) Database that is accessed by my professional discipline manager/senior allied health professional or allied health director and the Chief Allied and Scientific Health Officer or delegate.</p> <p>Signature: _____ Date: / /</p>

PART 5 - DECLARATION BY PROFESSION MANAGER / SENIOR AHP

I am satisfied that the applicant has the appropriate credentials to undertake the position for which they are being employed within SA Health.

Identified scope of clinical practice (as per Part 2):* _____

Allied Health Advanced Clinical Practitioner: Yes No

Restrictions or Limitations (as per Part 2): N/A or Specify _____

Signature: _____

Date: / /

Name of Profession Manager/Senior Allied and Scientific Health Professional: _____

Position Title: _____ Health Unit: _____

Credentialing Committee: _____

Date of Credentialing Approval <i>(Date signed by Manager/Senior ASHP)</i>	/ /
Credentialing Expiry Date:	/ /

*If identified scope of clinical practice includes Advanced or Extended Scope of practice, additional documentation, evidence and monitoring of competency will be required according to the specific scope and LHN procedures.

On completion, please provide applicant with a copy of the signed credentialing application.

All details from this form, along with a copy of the application form and transcript/parchment of relevant qualifications for self-regulated professions and CV should be uploaded to the relevant fields into the SA Health Credentialing and Scope of Clinical Practice System for Health Practitioners (CSCPS) database.

Application form and copies of supporting evidence should also be submitted to HR/kept on secure file by Manager as per local procedures.

Original criminal history clearance documents and AHPRA registration certificates should be returned to the applicant and copies disposed of confidentially once data has been entered into the database.

OFFICE USE ONLY	
Application details entered into CSCPS	Date: / /
Name:	Position:
Signature:	