SA Health Allied & Scientific Health Professional
Initial Credentialing Application

This form is for use by **allied and scientific health professionals employed by SA Health and not previously credentialed** in accordance with the Authenticating Allied Health Professionals Credentials Policy Directive (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: _______ / _______ / _______ **Gender:** _______________________________

Email: __________________________________ **Phone:** ________________________________

Job Title & Profession: ____

Site & Health Unit/ Clinical Service: ____

	Manager Sign Off
NON-AUSTRALIAN RESIDENTS ONLY - *if yes, please attach a copy to this application* Do you require a Work Visa to practise in Australia? ☐ Yes ☐ No	☐ N/A or ☐ Attached
CURRICULUM VITAE (CV) demonstrating appropriate experience & recency of practice for the role to be undertaken ☐ Attached	☐ Assessed as suitable

REQUESTED LHNS FOR CREDENTIALING

☐ CALHN ☐ NALHN ☐ SALHN ☐ WCHN ☐ Regional LHNs ☐ SCSS

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: ☐ No ☐ Yes If yes, please specify: _________________________ Do you hold AHPRA endorsement in a specific area of practice? ☐ No ☐ Yes – if yes, please specify____________________________________	☐Registration (+/- endorsement) details sighted on AHPRA website Date sighted:
Evidence of Continuing Professional Development (CPD) to the level required by your registration type: ☐ Attached 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*) ☐ Yes - Advanced Scope ☐ Yes - Extended Scope Please specify training/qualification and scope of practice: __________________ ____ Do you undertake this advanced or extended scope in your current role? ☐ No ☐ Yes – if yes, manager must approve for current role	☐ Evidence of CPD received Scope of practice in current role: ☐ Standard scope of practice (profession) OR ☐ Advanced scope of practice as specified OR ☐ Extended scope of practice as specified
Medical Radiation Professions Only: LSPN: _______________ EPA radiation licence number: _____________ Expiry Date: / /	☐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 Professional Association: ______________________________ Eligible for Membership ☐ Yes ☐ No Are there any restrictions or special conditions placed on your professional association membership/eligibility? ☐ Yes ☐ No If yes, please specify: ______________________________	☐Qualification transcript or certificate sighted Date sighted: ☐ Eligibility for membership confirmed
Do you hold formal Accreditation? ☐ Yes ☐ No If yes, please specify accrediting body, type/title, number & date of expiry of accreditation: ______________________________ ______________________________	☐Evidence of accreditation sighted Date sighted:
Evidence of participation with Continuing Professional Development (CPD) attached: Self-managed portfolio in accordance with guidelines set by Professional Assoc ☐ Accredited/formal CPD program with specified points/hours ☐	☐ Evidence of CPD received
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*) ☐ Yes - Advanced Scope – please specify training/qualification and scope: ______________________________ ☐ Yes - Extended Scope – please specify training/qualification and scope: ______________________________ Do you undertake this advanced or extended scope in your current role? ☐ No ☐ Yes *(if yes, manager must approve for current role)*	Scope of practice in current role: ☐ Standard scope of practice (profession) OR ☐ Advanced scope of practice as specified OR ☐ Extended scope of practice as specified
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.	

C. UNREGULATED PROFESSION	Manager Sign Off
Profession of Applicant: ______________________________ Allied Health discipline applicant is affiliated with: ______________________________ Original transcript of primary and/or postgraduate qualification from relevant training program attached ☐ Yes ☐ N/A	☐Qualification sighted Date sighted: OR ☐ N/A for this role

PART 3 - NATIONAL CRIMINAL HISTORY SCREENING	Manager sign off
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 check(s) are required for the role(s). Please review the Criminal and Relevant History Screening Policy to confirm the timeframe within which each type of check must be issued.	
Complete details for all criminal history checks you hold. **National Police Clearance (NPC)** noting unsupervised contact with vulnerable groups Date of issue: / / Reference Number: ____________________ **DHS Criminal History Screening** Working With Children Check (WWCC) Date of issue: / / Reference Number: ____________________ NDIS Worker Check Date of issue: / / Reference Number: ____________________ Vulnerable Person-Related Employment Check Date of issue: / / Reference Number: ____________________ Aged Care Sector Employment Check Date of issue: / / Reference Number: ____________________ General Employment Probity Check Date of issue: / / Reference Number: ____________________	☐ Evidence sighted Date sighted:

PART 4 – DECLARATION BY APPLICANT
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. I undertake to inform my employer of any complaint made about my professional conduct or of any change in registration/professional membership status. 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. Signature: ____ Date: / /

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):* ____

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

Signature: ______________________________ **Date**: / /

Name of Profession Manager/Senior Allied Health Professional: ________________________

Position Title: ___________________________ ___ **Health Unit**: ______________________

Credentialing Committee: ____

Date of Credentialing Approval *(Date signed by Manager/Senior AHP)*	/ /
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:	