SA Health Allied and Scientific Health Professional
Re-Credentialing Application

This form is to be used by **allied and scientific health professionals (ASHPs) employed by SA Health who have been 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: _____

Have you previously been credentialed within a Local Health Network (LHN)/Clinical Service of SA Health?

☐ Yes – specify: _____ ☐ No – *do not use this form. Complete Initial Application.*

REQUESTED LHNS FOR CREDENTIALING

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

PART 2 – PROFESSION & SCOPE OF CLINICAL PRACTICE *(complete section A, B or C as relevant)*

A. REGISTERED PROFESSION

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_____

Evidence of participation in 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 – please specify training/qualification and scope:

_____

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

_____

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

☐ No ☐ Yes – if yes, manager must approve for current role

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

☐ No ☐ Yes

Medical Radiation Professions Only: LSPN: _____

EPA radiation licence number: _____ Expiry Date: / /

Manager Sign Off

☐ Registration (+/- endorsement) details sighted on Board website

Date sighted:

☐ 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

☐ Allied Health Advanced Clinical Practice Credentialing Portfolio (if applicable)
Date sighted:

☐ Licence details sighted

Date sighted:

B. SELF-REGULATED PROFESSION	Manager Sign Off
Profession: _____	Qualification confirmed: ☐ on CSCPS *OR* ☐ original provided
Evidence of primary and/or postgraduate qualification from an accredited/ recognised university training program ☐ held on CSCPS ☐ attached	
Professional Association: _____	
Eligible for Membership ☐ Yes ☐ No	☐ Eligibility for membership confirmed
Are there any restrictions or special conditions placed on your professional association membership/eligibility? ☐ Yes ☐ No	
If yes, please specify: _____	
Do you hold formal Accreditation? ☐ Yes ☐ No	☐ Evidence of accreditation sighted
If yes, please specify accrediting body, type/title, number & date of expiry of accreditation: _____ _____	Date sighted:
Evidence of participation with Continuing Professional Development (CPD) attached:	☐ Evidence of CPD received
Self-managed portfolio in accordance with guidelines set by Professional Assoc ☐	☐ Appropriate recency of practice confirmed
OR Accredited/formal CPD program with specified points/hours ☐	
Confirmation of appropriate recency of practice for the profession and role to be undertaken (recent SA Health role or CV or referee checks) ☐	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	
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
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). Criminal history screening and information about these requirements is available via the *SA Health Criminal and Relevant History Screening Policy.*	
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: OR ☐ N/A (if service does not require renewal of criminal history screening or previous screenings remain in-date)

PART 4 – MONITORING CLINICIAN PERFORMANCE	Manager sign off
Under the National Safety & Quality Healthcare Standards (Version 2), SA Health is required to monitor clinicians' performance to ensure the delivery of safe, quality care in all health services. This monitoring is undertaken via a number of clinical governance policies and procedures, including but not limited to requirements under the Clinical Supervision Framework and Performance Review & Development policies.	
CLINICAL SUPERVISION	
Consistent with the SA Health Clinical Supervision Framework, I receive regular clinical supervision from a suitably qualified and experienced allied health professional. Date of most recent supervision session: / /	☐ Regular participation confirmed (via discussion with supervisor or review of supervision log)
PERFORMANCE REVIEW AND DEVELOPMENT (PR&D)	
I participate in six-monthly PR&D process, consistent with the SA Health Performance Review & Development (PR&D) Policy Directive. ☐ Confirmed	Date of last PR&D:

PART 5 – 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 6 - DECLARATION BY PROFESSION MANAGER / SENIOR ASHP

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):* _____

Performing at advanced clinical practice level (if employed as an Advanced Clinical Practitioner) ☐ Yes ☐ No

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

Signature: _____ **Date**: / /

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

Position Title: _____ **Health Unit**: _____

Credentialing Committee: _____

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

*If 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 Board 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:		