Specialist Registration and Accreditation

Please fill out the form below and upload required documents

Name *

First Name Middle Name Last Name

Preferred Title

E.g. Mr, Dr, Prof

Qualifications *

Email *

example@example.com

Specialty *

Date of Birth *

Day Month Year

Australian Residency Status *

Contact Details

Mobile Phone *

Business/Practice Phone *

Business/Practice Email *

example@example.com

Business/Practice Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Business/Practice Website

Enter your professional website details here

Registration Details

AHPRA Registration Number *

AHPRA Registration Expiry Date *

Day Month Year

Have you ever been the subject of prior disciplinary decisions or rulings imposed by any registration board whether in Australia or elsewhere? *

- ☐ Yes
- ☐ No

Have you had your professional registration revoked, suspended or amended (including the imposition of any conditions)? *

- ☐ Yes
- ☐ No

Have you had the initiation of any process, inquiry or investigation by the relevant board or coroner or tribunal (or equivalent body in any other jurisdiction, as applicable) or a health care complaints body (howsoever described) involving you or the initiation of a legal process relevant to the medical practice which impacts or arises from your practice of medicine? *

- ☐ Yes
- ☐ No

If you answered "yes" to any of the above three questions please provide details *

Are you a recognised specialist under the relevant jurisdiction for the purposes of the payment of Medicare benefits for your patients? *

- ☐ Yes
- ☐ No

Prescriber Number

Provider Number

Please enter you main provider number

Medical Indemnity Details

Insurance Company *

Enter your medical indemnity insurer e.g. AVANT

Membership Number *

Insurance Expiry Date *

Day Month Year

Does your membership fully cover the scope of clinical practice you have applied for in this application? *

- ☐ Yes
- ☐ No

Have you had any change in your Professional Indemnity Insurance, including but not limited to the attaching of conditions, non-renewal or cancellation? *

- ☐ Yes
- ☐ No

Have you ever had an adverse finding (formal or informal, current or former) made against you by any registration, disciplinary, investigative or professional body? *

- ☐ Yes
- ☐ No

If you answered "yes" to any of the above two questions please provide details *

Hospital Accreditations

Please list all of the private and public hospitals you work at/hold accreditation *

Have you ever been denied a scope of practice that you requested? *

- ☐ Yes
- ☐ No

Have you had your Appointment of Accreditation or Scope of Clinical Practice at, any other facility, hospital or day procedure centre altered in any way other than at your request? *

- ☐ Yes
- ☐ No

If you answered "yes" to any of the above two questions please provide details *

Police Check/Criminal History Check

Have you undergone a police check / criminal history check within the last six months? *

- ☐ Yes
- ☐ No

Have you been charged with, or convicted of, any indictable offence or under any laws that regulate the provision of health care or health insurance? *

- ☐ Yes
- ☐ No

Are you the subject of pending criminal charges? *

- ☐ Yes
- ☐ No

If you answered "yes" to any of the above two questions please provide details *

Do you have a current Working With Children (WWC) Check? *

- ☐ Yes
- ☐ No

WWC Card Number

WWC Card Expiry Date

Day Month Year

Referees

Please provide the names and phone number of two referees within your specialty *

Patient Selection & Availability

Please choose the patient categories you are happy to provide telehealth consultations for *

- ☐ Privately Insured Patients
- ☐ Public Uninsured Patients
- ☐ International Patients
- ☐ Workcover Patients
- ☐ DVA Patients
- ☐ TAC/Other Road Accident Compensation Scheme Patients

Are you prepared to allocate protected availability for telehealth consultations? *

- ○ Yes
- ○ No

When would you be happy to consult? (Upon accreditation we will set up provisional consulting times with you) *

- ☐ Weekends
- ☐ Out of hours
- ☐ Business hours only
- ☐ Anytime

Billings & Payments

What is your current new patient consulting fee? *

What is your current follow up patient consulting fee? *

If applicable, what is your standard surgical billing practice? *

- ☐ No Gap
- ☐ Known Gap
- ☐ 100% AMA schedule fee
- ☐ 75-100% AMA schedule fee
- ☐ > 100% AMA schedule fee
- ☐ Im flexible it depends on the operation to be performed and the individual patient circumstance

ABN

Please Enter Your ABN Number *

Please email your completed registration form with the documents in the checklist below to specialist@specialistbooking.com

Accreditation Document Checklist *

- ☐ Current AHPRA Registration Certificate
- ☐ Current Medical Indemnity Registration Certificate
- ☐ Current Police Check Certificate
- ☐ Current Continuing Professional Development (CPD) Certificate
- ☐ Current CV
- ☐ Current drivers license for identification purposes
- ☐ Current passport or medicare card for identification purposes