



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

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