AMBULATORY SURGERY INITIATIVE

Department of **Health**
Government of **Western Australia**

PROTOCOL REGISTRATION FORM

Protocol Applying to Medical Practitioners Participating in the Ambulatory Surgery Initiative

Important Information
This is the Protocol Registration Form applying to Medical Practitioners participating in the Ambulatory Surgery Initiative. If there is anything in this form that you do not understand please contact the Director of Medical Services or equivalent at the relevant hospital or health service.

1. Personal Details *(please print)*

Title	*Surname*	*First name*	*Other name(s) – initial(s)*

Male ☐ *Female* ☐ *Address*

Postcode

Mailing address (if different from above)

Postcode

Contact Business ( )	*Facsimile number* ( )
Home / Mobile	*Email*

2. Medical Qualifications

Degree *(or equivalent)*	University	Year	Degree *(or equiv.)*	University	Year

3. Medicare Provider Number

4. Medical Board of Australia Registration Number — MED 000 _ _ _ _ _ _ _

When were you first registered in Australia as a medical practitioner? YEAR

5. Have you ever received an adverse finding in relation to prescribing, billing or any other matter by a court, tribunal or other statutory body? *If 'yes' please provide details* YES ☐ NO ☐

6. Are you working under a Medical Practitioner Visa (subclass 422) or a Temporary Business (Long Stay) - Standard Business Sponsorship (Subclass 457)? YES ☐ NO ☐

If 'yes', (a) please indicate your intended departure date (if known) _____ / _____ / 20____

(b) provide the dates of any previous work you have done in Australia

7. Are you working through a locum service? YES ☐ NO ☐

If 'yes' please provide the name of the locum agency .....

8. Area of Practice *(please tick relevant box)*

☐ Specialist *(please state Speciality)*

☐ Other *(please specify)*

If the space provided for details is insufficient, please attach a separate statement.

9. DECLARATION

I wish to register for the "Protocol Applying To Medical Practitioners Participating In The Ambulatory Surgery Initiative And/Or The Privately Referred Non-Inpatients Model" (June 2006) which I provide at:

Name of Hospital

By signing this Form:

(a) I declare that to the best of my knowledge and belief the information provided in this registration form is true and correct and I have not withheld any relevant information.

(b) I consent to personal information provided by me to be shared by the Department of Health, or as required by law. I consent to the Department of Health also disclosing personal information to and/or collecting additional information from investigators, legal advisers, medical advisers, actuaries or other advisers whom the Department of Health may engage to assist in processing this proposal for the Protocol and any subsequent claims.

(c) I agree to comply with the Business Rules applying to the Ambulatory Surgery Initiative (as varied from time to time).

Please Sign And Date Here

Signature _____ Date _____

Please print your name _____

10. OFFICE USE ONLY

Number

An authorised officer is to complete this section.

I confirm the above medical practitioner is eligible to register for the Protocol applying to Medical Practitioners participating in the Ambulatory Surgery Initiative.

Signature	Date
Full name	
Position	phone number
Name of Hospital	
Address	

IMPORTANT

When the above section (10) has been completed, the hospital to copy (x 2) the application.

(a) the original to be retained by the hospital

(b) one copy is to be sent to the medical practitioner for his/her personal record, and

(c) one copy is to be mailed to

Legal & Legislative Services
Department of Health
PO Box 8172
Perth Business Centre WA 6849

25/02/2011