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

RiskCover

APPLICATION FORM

Application for the Medical Indemnity applying to the Privately Referred Non-Inpatient Model

effective 1 September 2013

Important Information

This is the application for the indemnity as set out in the "Terms and Conditions of the Medical Indemnity applying to the Privately Referred Non-Inpatient Model". The Indemnity is a legally binding contract based on the information you have provided about your professional practice. If there is anything in this application form that you do not understand please contact the Director of Medical Services at your hospital.

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. What is your Medical Board Registration Number? REGISTRATION NUMBER

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

5. Do you currently have or have you ever had restrictions placed on your registration in any country including Australia? YES ☐ NO ☐

6. Have you ever been deregistered, refused registration or suspended from practice as a medical practitioner in any country including Australia? YES ☐ NO ☐

If 'yes' to Q5 or Q6 please provide details on a separate sheet.

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

   (a) please indicate your intended departure date (if known) _____/_____/_____

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

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

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

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

☐ Specialist *(please state Speciality)*

☐ Other *(please specify)*

10. Do you practice primarily in the metropolitan area? YES ☐ NO ☐

11. Have you ever had your visiting rights reduced or suspended in any country and / or at any hospital / health service? *If 'yes' please provide details.* YES ☐ NO ☐

12. Are you a member of a Medical Defence Organisation or hold a professional indemnity / insurance policy? *If 'yes', please provide name of the MDO/ insurer* YES ☐ NO ☐

_____

13. Have you ever been refused medical indemnity insurance or membership or had an application for renewal declined in any country including Australia YES ☐ NO ☐

    If 'yes' please provide details on a separate sheet.

14 Have you had any claims made against you in the past five years involving medical services provided to a public or private patient in any country including Australia? YES ☐ NO ☐

    If 'yes' please provide detail on a separate sheet - exclude any matters previously notified to DoH.

15. Have you ever had or do you know of any claims, demands, suits, restrictions or other legal actions brought or threatened against you in respect to your conduct as a medical practitioner? YES ☐ NO ☐

    If 'yes', on a separate sheet, please indicate what these have been and give details including when you notified your insurer about the matter and whether or not the matter has been resolved - exclude any matters previously notified to DoH

16. Are you aware of any particular circumstances that may give rise to a claim, demand, suit or legal action being brought or threatened against you now or in the future? YES ☐ NO ☐

    If 'yes' please provide details on a separate sheet - excluding any previously notified to DoH

17. Have you ever received an adverse finding in relation to prescribing, billing or any other matter by a court, tribunal or other statutory body? YES ☐ NO ☐

    If 'yes' please provide details on a separate sheet

18. Have you ever been disciplined or counselled in relation to the use of alcohol or drugs? YES ☐ NO ☐

    If 'yes 'please provide details, including date(s) and location(s), on a separate sheet.

19. Have you previously applied for medical indemnity cover provided through the Department of Health YES ☐ NO ☐

if 'yes' please state type (eg salaried medical officer or non-salaried medical practitioner).

20. If 'yes' to Q 19, please tick the Service where the application was submitted.

North Metro Area Health Service (including KEMH)	☐	South Metro Area Health Service	☐
WA Country Health Service	☐	Child and Adolescent Health Service	☐

see page 4

21. DECLARATION

I wish to apply for the Minister for Health's "Medical Indemnity applying to the Privately Referred Non-Inpatients Model" (as described in the "*Terms and Conditions of the Medical Indemnity applying to the Privately Referred Non-Inpatients Model – effective 1 September 2013"*) which I provide at:

Name of Hospital(s)

By signing this Application Form:

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

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

(c) I acknowledge that I have read and understood the "Terms and Conditions of the Medical Indemnity applying to the Privately Referred Non-Inpatients Model" as available on the website at http://www.health.wa.gov.au/indemnity/ or on request.

(d) I agree to be bound by the "Terms and Conditions of the Medical Indemnity applying to the Privately Referred Non-Inpatients Model".

Please Sign And Date Here

Signature _____ Date _____

PLEASE PRINT YOUR NAME ➔ _____

22. *OFFICE USE ONLY*

Indemnity Number

An authorised officer at the hospital or health service is to complete this section.
"The Minister for Health accepts this Application Form"

Signature	Date
as delegate for the Minister for Health Full name	
Position	phone number
Name of Hospital	
Address	

IMPORTANT When the above section (22) 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