SA Health Allied Health Professional
Application for an Access Appointment

This form is for use by **allied and scientific health professionals NOT EMPLOYED BY SA HEALTH including private, non-government, other Government or Education Providers** in accordance with the Authenticating Allied Health Professionals Credentials Policy Directive (including registered, self-regulated & relevant unregulated professions).

PART 1 – APPLICANT DETAILS

Title : ____________________ **SA Health Employee: NO**

Surname: _________________________________ **First Name:** ____________________________

Middle Name/s: ____________________________ **Previous Name/s:** _______________________

Date of Birth: _______ / _______ / _______ **Gender:** _______________________________

Email: ____ **Phone:** ________________________________

Profession: ____

Employing Organisation: ____

Work Address: ____

	SA Health Sign Off
NON-AUSTRALIAN RESIDENTS ONLY - *if yes, please attach a copy to this application* Do you require a Work Visa to practise in Australia? ☐ Yes ☐ No	☐ N/A or ☐ Attached
CURRICULUM VITAE (CV) demonstrating appropriate experience & recency of practice for the role to be undertaken **-** *please attach a copy*	☐ Assessed as suitable
PROFESSIONAL INDEMNITY INSURANCE – *please attach certificate* Insurance Company ____ Policy Type: ____ Policy Number: _______________________________ Expiry: / /	☐ Attached

REQUESTED LHNS FOR CREDENTIALING

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

TYPE & DURATION OF ACCESS APPOINTMENT

Type of Clinical Service: *please tick*

☐ Private Allied Health Professional providing fee for service clinical care to clients located in an LHN facility

☐ Other Government Agency, Non-Government Organisation or Education Provider (e.g. clinicians, clinical educators, researchers) providing clinical services to patients/clients in an LHN facility or accessing clinical information of patients/consumers

☐ Unpaid access appointment such as professional volunteers providing clinical services to patients/clients

☐ Other, please describe:____

Type of access required: ☐ Single client ☐ Multiple clients

Term of Access Appointment required:___________________________ **to** ______________________________

Key Contact at LHN(s): *This is the Allied Health Manager/Senior AHP responsible for providing orientation/access to site and applicant must contact this person prior to attending the site(s).*

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

A. UNREGULATED PROFESSION	SA Health Sign Off
Profession of Applicant: ____ Allied Health discipline applicant is affiliated with: ___________________________ Original transcript of primary and/or postgraduate qualification from relevant training program attached ☐ Yes ☐ N/A	☐ Qualification sighted Date sighted: OR ☐ N/A for this role

B. SELF-REGULATED PROFESSION	SA Health Sign Off
Profession: ____	Qualification confirmed:
Evidence of primary and/or postgraduate qualification from an accredited/ recognised university training program attached ☐ held on CSCPS ☐ attached	☐ on CSCPS OR ☐ original provided
Professional Association: ____	Date sighted:
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 Accreditation? ☐ Yes ☐ No	☐ Evidence of accreditation sighted
If yes, please specify accrediting body and type/title of accreditation: ____	Date sighted:
Evidence of participation with Continuing Professional Development (CPD) attached: Self-managed portfolio in accordance with guidelines set by Professional Assoc ☐ OR Accredited/formal CPD program with specified points/hours ☐	☐ Evidence of CPD received
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: ____	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
Do you undertake this advanced/extended scope in your role within SA Health sites? ☐ No ☐ Yes (if yes, SA Health contact must approve for role in SA Health sites)	
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.	

C. REGISTERED PROFESSION	SA Health Sign Off
Profession: ______ Registration Number: ______ Expiry Date: / / Registration Type: ______ Conditions: ☐ No ☐ Yes If yes, please specify: ______	☐ Registration details sighted on AHPRA website Date sighted:
Evidence of Continuing Professional Development (CPD) to the level required by your registration type: ☐ Attached	☐ Evidence of CPD received
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 ☐ Yes - Extended Scope Please specify training/qualification and scope of practice: ______ ______ Do you undertake this advanced/extended scope in your role within SA Health sites? ☐ No ☐ Yes – if yes, manager must approve for role in SA Health sites Do you hold AHPRA Endorsement in a specific area of practice? ☐ No ☐ Yes – if yes, please specify______	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
Medical Radiation Professions Only: LSPN: ______ EPA radiation licence number: ______ Licence Expiry Date: / /	☐ Licence details sighted Date sighted:

PART 3 - NATIONAL CRIMINAL HISTORY SCREENING	SA Health Sign Off
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 SA Health Key Contact(s) as to what checks are required for their role(s). Please review the Criminal and Relevant History Screening Policy to confirm the timeframe within which each type of check must be issued.	
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:

PART 4 – 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 the SA Health key contact to seek information relating to my credentials and experience as relevant to my application.

I undertake to inform SA Health of any complaint made about my professional conduct or of any change in registration/professional membership eligibility 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 professional discipline manager/senior allied health professional or allied health director and the Chief Allied and Scientific Health Officer or delegate.

I confirm there is an appropriate contract or agreement in place with SA Health (directly or via an employer), detailing the arrangements for service delivery. I additionally agree to comply with mandatory training and other relevant policies (e.g. immunisation directive) applicable to the LHN and scope of practice being undertaken.

Signature: ____ Date: / /

PART 5 - DECLARATION BY PROFESSION MANAGER / SENIOR AHP (SA Health Key Contact)

I am satisfied that the applicant has the appropriate credentials to undertake the position for which they are being engaged within SA Health.
Identified scope of clinical practice (as per Part 2):* ____

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

Signature: ____________________________________ **Date**: / /

Name of Profession Manager/Senior Allied Health Professional: ______________________________

Position Title: _____________________________________**Health Unit**: ______________________________

Credentialing Committee: ____

Date of Credentialing Approval	**/ /** *(Date signed by SA Health Key Contact)*
Credentialing Expiry Date:	**/ /**

*If scope of clinical practice includes Advanced or Extended scope, 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 this Access Appointment application.

All details from this form, along with a copy of the application form, CV and transcript/parchment of relevant qualifications (self-regulated professions only) 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 be submitted to HR/kept on secure file by Key Contact as per local procedures.

Original documents for criminal history checks and AHPRA 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:		

CONDITIONS FOR ACCESS APPOINTMENTS IN SA HEALTH

Scope:
An Access Appointment grants an Allied Health Professional (AHP) external to SA Health credentialing approval to provide clinical services within an SA Health site. External Allied Health Professionals are required to comply with SA Health's *Authenticating Allied Health Professionals Credentials including Access Appointments* Policy and other relevant procedures.

Conditions:

1. The Access Appointee must comply with all relevant policies and procedures of the Local Health Network (LHN) and the relevant Health Unit, including documentation and Occupational Health and Safety (OH&S).

2. The Access Appointee can expect to receive appropriate orientation to the Health Unit/clinical service.

3. During the term of the Access appointment, it is required that the Access appointee must:

   3.1. Maintain current Credentials as per the 'Authenticating Allied Health Professionals Credentials including Access Appointments Directive Policy' available at www.health.sa.gov.au/alliedandscientifichealth

   3.2. Only provide services that are within the ambit of the Access Appointee's credentials, are appropriate to the resources available, and are within the approved scope of practice, at the relevant LHN, Health Unit or clinical service.

   3.3. Maintain current, both Professional Indemnity and Public Liability insurance, to the value of $10,000,000 each at all times to cover any liability that may arise out of or as a consequence of the Access Appointee providing services at the relevant LHN, Health Service or clinical service. Provide insurance policy details to the Health Unit or clinical service. If providing clinical services to DVA clients refer to the Commonwealth Department of Veteran Affairs for appropriate Professional Indemnity coverage and Public Liability Insurance cover amounts.

   3.4. For Unpaid appointees, Indemnity and Liability insurance arrangements must be agreed at the local site level prior to commencement of visitations or clinical placements.

   3.5. In the event that an Access Appointee becomes involved in any criminal or disciplinary proceedings arising out of their practice, the Access Appointee must give the LHN and Health Unit/clinical service written notice of those proceedings within fourteen (14) days of commencement. The LHN/clinical service may also undertake continuous monitoring of relevant criminal history screening through the Department of Human Services (DHS) Portal relating to Working With Children Checks and DHS Child-related clearances.

   3.6. In the event a claim is made against an Access Appointee or they become involved in any civil proceedings arising out of their practice at the relevant LHN, Health Service/clinical service the Access Appointee must give the LHN, Health Unit/clinical service written notice of those proceedings within fourteen (14) days of commencement.

4. The Access Appointee must observe and otherwise provide services to patients at the relevant LHN, Health Service/clinical service in accordance with the terms, conditions, rules and regulations set out in the relevant Registration Board and/or Professional Association's Code of Professional Conduct.

5. The LHN Director of the relevant Health Unit/clinical service in conjunction with the Profession Manager/Senior Allied Health Professional may terminate the Access Appointment immediately by notice in writing to the Access Appointee in the event that:

   5.1. The Access Appointee breaches any terms and conditions for the Access Appointment.

5.2. The Access Appointee is involved in any activity or conduct which in the opinion of the LHN, Health Unit/clinical service might adversely affect the quality and safety of the patient/client care provided at the relevant Health Unit/clinical service.

5.3. The Access Appointee is deemed by the LHN, Health Unit/clinical service to be a risk to patients, jeopardising the health and safety of patients/clients and/or staff or otherwise exposing the relevant Health Unit/clinical service to a risk of liability in respect to the services provided to patients.

5.4. The Access Appointee is guilty of gross misconduct or neglect in the discharge of their duties.

5.5. The Access Appointee has become of unsound mind.

The Profession Manager/Senior Allied Health Professional has a legal obligation to notify AHPRA if a registered Access Appointee's professional conduct or behaviour is such that it is outlined by the above clauses 5.2 to 5.5.

6. An Access Appointee's Appointment will terminate automatically if for any reason the applicant ceases to hold appropriate credentials.

7. Following the expiry of the Access Appointment approval, an applicant must reapply for a renewal of the Access Appointment to continue practising in the relevant LHN, Health Unit/clinical service. Renewal is required on an annual basis.

8. Following the termination or expiration of the Access Appointment, the Appointee must continue to maintain professional indemnity insurance referred to in paragraph 3.4, or appropriate run-off insurance, to ensure cover in respect to any claim which might be made against the Appointee in respect to services provided at the relevant LHN, Health Unit/clinical service during the approved term of Access Appointment.

DECLARATION

I have read, understood and agree to abide by the above Conditions if granted an Access Appointment by the Local Health Network, Health Unit/clinical service.

I confirm I will liaise with the SA Health Key Contact (usually the Allied Health Manager/Senior AHP of the relevant profession) prior to attending the Local Health Network, Health Unit/clinical service in order to receive orientation information and confirm arrangements relating to attendance at the site and provision of the service.

____________________________	____________________________
APPLICANT NAME	**WITNESS NAME**
____________________________	____________________________
APPLICANT SIGNATURE	**WITNESS SIGNATURE**
____________________________	____________________________
DATE	**DATE**