

## APPLICATION FOR OBSTETRIC SHARED CARE ACCREDITATION

### PERSONAL DETAILS

Title \_\_\_\_\_ Given Name \_\_\_\_\_ Surname \_\_\_\_\_

Female

Male

General Practitioner

GP Obstetrician

### PRACTICE ADDRESSES

Please indicate preferred practice for general correspondence by a tick next to number

1) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Mobile \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

2) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Mobile \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

RACGP QA&CPD No \_\_\_\_\_ ACRRM No \_\_\_\_\_ Division/Network \_\_\_\_\_

### PROFESSIONAL REQUIREMENTS

All applicants for Obstetric Shared Care accreditation must provide evidence of each of the following:

Current Registration with Australian Health Practitioner Regulation Agency

Registration number \_\_\_\_\_

(Please attach copy of AHPRA Registration)

Current Medical Indemnity/Insurance membership

Name MDO/Insurer \_\_\_\_\_

Membership number \_\_\_\_\_

(Please attach copy of Medical Indemnity Insurance)

## OBSTETRIC EXPERIENCE

DRANZCOG with current recertification

Diploma Obstetrics RACOG (no recertification required) or CSCT in Women's health  
**plus** recent involvement in provision of antenatal care. Please list at least one hospital sites involved

Hospital \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact number \_\_\_\_\_

Hospital \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact number \_\_\_\_\_

FRANZCOG/FRACOG      Date attained \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital Experience as an Antenatal Care Provider:

Please outline and attach details, including accreditation at other hospital sites, dates, contact names and phone numbers.

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Applications for accreditation will be considered on an individual basis for GPs who can demonstrate significant hospital experience/qualifications/professional development/accreditation in the provision of antenatal care.

## PROFESSIONAL REFEREES (medical)

All applicants for Obstetric Shared Care accreditation must provide two professional medical referees.

One referee is to be a current Obstetric Shared Care GP or Obstetrician

Name \_\_\_\_\_ Contact number \_\_\_\_\_

Practice/ Hospital \_\_\_\_\_ Position \_\_\_\_\_

Name \_\_\_\_\_ Contact number \_\_\_\_\_

Practice/ Hospital \_\_\_\_\_ Position \_\_\_\_\_

**AGREEMENT**

As an Obstetric Shared Care Provider, I agree to all of the following undertakings:

- I have knowledge and understanding of the protocols for shared antenatal care
- I will participate in appropriate continuing professional development to obtain and maintain accreditation, as specified in the Obstetric Shared Care protocols
- I will ensure that GP partners Adelaide has up to date preferred contact information (telephone, facsimile, postal address)
- I will observe hospital guidelines in respect of mutual patients, including criteria for hospital review/referral
- My Medical Registration is current and without conditions and I will notify the Obstetric Shared Care coordinator if my registration is suspended, cancelled or has restrictions imposed
- My Medical Indemnity/Insurance will be maintained at an adequate level of cover for the duration of my participation in Obstetric Shared Care
- I will keep appropriate clinical records
- When on leave or ill appropriate arrangements be made for continuing care with an accredited Shared Care provider or the participating hospital
- I authorize the hospitals to provide women and their families with my practice details
- I understand that if I do not follow protocols and attend relevant CPD my accreditation status will be withdrawn

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please sign and return this form and copies of relevant documentation to*

GP Obstetric Shared Care  
GP partners Adelaide  
PO Box 7293  
HUTT ST, SA 5000

**GP Obstetric Shared Care (Office Use Only)**

Date application received ____/____/____		Antenatal clinic attendance required?		Yes	No
<b>Accreditation approved as:</b>	Application	Provisional	Full Accreditation		
	Spec Obstetrician	Rural GP Obstetrician			
Date ____/____/____					
Clinic attendance dates	____/____/____	____/____/____	____/____/____		
	____/____/____	____/____/____	____/____/____		
Accreditation Seminar Date	____/____/____				
Operations Group delegate name	_____		Signature	_____	
Database entry date	____/____/____				