**Application for Midwife Credentialing**

**as a Shared Maternity Care Affiliate**

**at Mercy Hospital for Women, The Royal Women’s Hospital and Western Health (Sunshine Hospital)**

**for the triennium 1 January 2023 – 31 December 2025**

###### PERSONAL DETAILS

Title: \_\_\_\_\_Given names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female  Male

Languages spoken (other than English): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special interests in addition to maternity care (may assist in our ability to refer women to you):

Adolescent health  Drug and Alcohol

Culturally diverse background  Counseling - please identify areas

Maternal child health  Refugee

Other – please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I wish to apply for credentialing as a Midwife Shared Maternity Care Affiliate at *(please tick one or more)*:**

Mercy Hospital for Women   Royal Women’s Hospital (Parkville)

Western Health (Sunshine Hospital)

***Please note that you only need to send the application to one site even if requesting credentialing at multiple hospitals***

**PRACTICE DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Primary Practice:**  This is my preferred mailing address  Yes  No  *If no please complete preferred mailing address section* | **Additional practice** | **Preferred mailing address**  (only complete if different from primary practice) |
| Practice name |  |  |  |
| Address  Suburb  Postcode |  |  |  |
| Phone |  |  |  |
| Fax |  |  |
| Mobile |  |  |
| Provider number |  |  |
| **Preferred email address\*** | | |

**\****Please note your privacy is assured. Your details will not be shared and will only be used for non-clinical communications from the Shared Maternity Care Collaborative Hospitals e.g. Newsletters, Educational activities etc.*

**PROFESSIONAL REQUIREMENTS**

All applicants for Shared Maternity Care Affiliate credentialing must provide evidence of each of:

Midwifery Qualifications

Graduation year: \_\_\_\_\_\_\_\_\_\_ Hospital/University: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Unrestricted Registration with Australian Health Practitioner Registration Agency **Please attach copy of current Registration**

Current Medical Indemnity Insurance Please attach copy of current Medical Indemnity Insurance **you are advised to ensure that your medical indemnity covers the provision of Shared Maternity Care**

Curriculum Vitae that specifically demonstrates your antenatal experience and evidence of recent professional development activities

**PROFESSIONAL REFEREES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Referee 1** |  | **Referee 2** |  |
| Name |  |  |  |  |
| Position |  |  |  |  |
| Contact Number |  |  |  |  |
| Email |  |  |  |  |
| Profession | SMCA | Midwife | SMCA | Midwife |
| Hospital/Practice |  |  |  |  |

Midwives who do not meet the postgraduate/experience requirements above may apply to attend antenatal sessions\* at one of the hospitals. Following clinic attendance and with the approval of a supervising midwife or obstetrician the application for SMCA credentialing will be processed.

*\*attendance at 1-6 sessions may be required, to be determined by the maternity director at one of the hospitals*

**AGREEMENT**

**As a Shared Maternity Care Affiliate of Mercy Hospital for Women, The Royal Women’s Hospital and Sunshine Hospital. I agree to all of the following undertakings:**

* I will review the guidelines the ‘Guidelines for Shared Maternity Care/Shared Maternity Care Affiliates, available via hospital websites
* I will observe hospital guidelines in respect of mutual patients, including criteria for hospital review/referral and sharing investigation results and management
* I will participate in appropriate continuing professional development for the provision of shared maternity care
* I will ensure the Shared Care Coordinators have up to date preferred contact information (telephone, facsimile, email, postal address)
* I will ensure the facsimile number given applies to a machine that is in a private location and procedures for handling patient information comply with privacy principles and legislation
* My Australian Health Practitioner Registration (midwife) is current and without conditions and I will notify the Shared Care Coordinators 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 Shared Maternity Care
* I will keep appropriate clinical records and document care in the patient’s handheld record (e.g. Victorian Maternity Record)
* I will make appropriate arrangements for continuing care with an accredited Shared Maternity Care Affiliate or the hospital where the woman is booked for birth when I am on leave or ill
* I acknowledge the hospitals conduct research activities and quality assurance programs and that Shared Maternity Care Affiliate or patient participation may be requested
* I authorise the hospital and their General Practice Liaison Units/Shared Care teams to discuss details of my provision of shared maternity care, both within the hospitals and between hospitals
* I authorise the hospitals to exchange details about my credentialing including contact details
* I authorise the hospitals to publicly publish and provide women and their families with my practice details, areas of interest and languages spoken
* I will not provide intrapartum care for women who are booked for maternity care or undertaking shared maternity care with the hospitals
* I understand that Shared Maternity Care Affiliates found not to be adhering to guidelines and acceptable standards of quality of care may have their credentialing status reviewed and revoked

NB: applications will not be proceed without copies of all supporting documentation.

I confirm the information provided is true and accurate and I agree to the undertakings listed in this agreement.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |
| --- | --- | --- |
| **Western Health (Sunshine Hospital)** | **The Royal Women’s Hospital** | **Mercy Hospital for Women** |
| Wendy Watson |  | Gillian Evans |
| Divisional Director for Women's & Children's Services | Shared Maternity Care Coordinator | Program Director Women’s & Children’s Services |
| 176 Furlong Road | Locked Bag 300 | 163 Studley Road |
| St Albans VIC 3021 | PARKVILLE VIC 3031 | Heidelberg VIC 3044 |
| T: 8345 0310 | T: 8345 2129 | T: 8458 4724 |
| F: 8345 0320 | F: 8345 2130 | F: 8458 4818 |

***HOSPITAL USE ONLY***

Date received: \_\_\_/\_\_\_/\_\_\_ Processing Hospital: RWH / MHW / WH

Date approved: \_\_\_/\_\_\_/\_\_\_ Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approval pack sent\_\_\_/\_\_\_/\_\_\_ Signature:

Antenatal clinic attendance required? Yes No

Number of clinic attendances recommended: (circle) 1 2 3 4 5 6 other (please specify) \_\_\_\_\_\_\_\_\_\_\_

Database entry date: \_\_\_/\_\_\_/\_\_\_ Copies of application sent to RWH / MHW / WH