

Shared Maternity Care Affiliate Credentialing Application Obstetricians

Triennium: 1 January 2023 – 31 December 2025

PERSONAL DETAILS

Title: _____ Given Names[^]: _____ Surname[^]: _____
 Preferred name: _____
 Gender: _____ Profession: _____
 Ahpra number: _____
 Personal email*: _____
 Mobile: _____
 Languages spoken (other than English): _____

[^] Name as listed on Ahpra register

* Optional - used for non-clinical communications from the Shared Maternity Care Collaborative Hospitals e.g. Newsletters, Educational activities etc.

PRACTICE DETAILS

Primary Practice

Secondary Practice

Practice name

Address

Suburb

Post code

Phone

Fax

Clinic email#

*# Email required for clinical communications and important updates
 If additional practice location, please attach list to application*

I wish to apply for Credentialing as a Shared Maternity Care Affiliate at:

All health services; **OR** (please tick one or more)

- | | |
|--|---|
| <input type="checkbox"/> Mercy Hospital for Women (Heidelberg) | <input type="checkbox"/> The Royal Women's Hospital |
| <input type="checkbox"/> Werribee Mercy Hospital | <input type="checkbox"/> Western Health (Joan Kirner Women's and Children's Hospital at Sunshine & Bacchus Marsh) |
| <input type="checkbox"/> Northern Health | |

Are you currently employed at any of the collaborative hospitals?

- No → Proceed to Section A and complete all sections of the form
- Yes → Please indicate your employer(s): Mercy Health NH RWH WH
 → Proceed to section D and sign the undertakings (do not complete sections A, B, C as your credentialing documentation will be checked with Human Resources at the relevant hospital/s)

Office Use Only Date received: ____/____/____ Date approved: ____/____/____ Approval pack sent: ____/____/____	Processing Hospital: MHW / RWH / NH / WH Approved by: _____ Signature _____ Copy to SMCC: ____/____/____
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SECTION A. Police & Identity Check

Please attach:

- Certified copy of [Proof of identity documents](#) adding to 100-point check
- [National Police Check](#) (this can be up to 12 months old from the date of submission of this application)

SECTION B. Professional Requirements

- Current unrestricted medical registration and specialist in Obstetrics and Gynaecology as per Ahpra
(to be checked by processing hospital)

Please attach:

- Certificate of Medical Indemnity Insurance

SECTION C. Professional Referees (medical)

Please provide two professional referees (Ahpra registered medical practitioners) who are in a position to comment on your experience and performance during the previous three years. It is preferable that at least one referee is a current shared maternity care affiliate (SMCA) or senior medical staff at any of the four hospitals. These referees will be contacted to provide a written reference.

	Referee 1	Referee 2
Name		
Position		
Contact Number		
Email		
Profession	<input type="checkbox"/> SMCA <input type="checkbox"/> Obstetrician	<input type="checkbox"/> SMCA <input type="checkbox"/> Obstetrician
Hospital/Practice		

SECTION D. Agreement

As a Shared Maternity Care Affiliate of Mercy Hospitals Victoria Limited, The Royal Women's Hospital, Western Health and Northern Health, I agree to all of the following undertakings:

- I will review the hospitals guidelines for 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 hospitals have up to date contact information (email, telephone, postal address) and will notify them if I move practices or my contact details change
- I will ensure patient information is held and managed in accordance with privacy legislation and standards
- My Medical Registration is current and without conditions and I will notify the hospitals 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 provide shared care in a clinic that is committed to providing high quality, safe care with appropriate clinical governance in line with the standards of the RANZCOG
- I will keep appropriate clinical records and communicate care with the hospitals
- I will make appropriate arrangements for continuing care with a credentialed Shared Maternity Care Affiliate or the hospital where the woman is booked for birth when I am not available
- 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 hospitals 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 my contact information and clinic details
- I authorise the hospitals to publicly publish and provide women and their families with my practice details, 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 (unless employed by the health service to provide intrapartum care)
- I understand that Shared Maternity Care Affiliates found not to be adhering to these agreements, guidelines and acceptable standards of quality of care may have their credentialing status reviewed and revoked at any time

I confirm that the information contained and provided is true and accurate and agree to the undertakings listed in this agreement (Section D).

Name: _____

Signature: _____

Date: _____

Checklist

- *Certified copy of Proof of Identity documents adding to 100-point check
- *National Police Check (last 12 months)
- *Certificate of Medical Indemnity Insurance
**If employed at one of the four health services, evidence not required*
- Signed & dated Section D Agreement

Please return this form and all supporting documents to the one health service that is closest to your practice (even if requesting credentialing at multiple hospitals) or (if relevant) the hospital you are employed at.

Mercy Health (Heidelberg and Werribee hospitals): primarycare@mercy.com.au

Northern Health: nh-primarycareliaison@nh.org.au

Royal Women's Hospital: gp.liaison@thewomens.org.au

Western Health (Sunshine and Bacchus Marsh hospitals): gp@wh.org.au