



Shared Maternity Care Partner Application

PERSONAL DETAILS

	Title_____	
	Given Names_____	Surname_____
<input type="checkbox"/>	General Practitioner	
<input type="checkbox"/>	Obstetrician	
<input type="checkbox"/>	Midwife	
	QI&CPD No_____	Languages_____

PRACTICE DETAILS	PRIMARY PRACTICE	ADDITIONAL PRACTICE
Practice name:		
Address:		
Suburb		
Postcode		
Telephone number:		
Fax number:		
Mobile:		
Email address:		
Date practice started:		

CURRICULUM VITAE AND PROFESSIONAL DEVELOPMENT

<input type="checkbox"/>	Curriculum Vitae attached including details of
1	Undergraduate & postgraduate experience & qualifications in obstetrics, gynaecology & women's health
2	Clinical Appointments
3	Academic appointments and teaching experience
4	Quality activities <i>Please include dates, fulltime equivalent loading, roles and responsibilities / tasks and the institutes(s) these were undertaken in</i>
<input type="checkbox"/>	Evidence of compliance with professional standard requirements as determine by relevant College (eg CPD statement for current and previous triennium)

PROFESSIONAL REFEREES	REFEREE 1	REFEREE 2
<i>Please provide two professional referees who are in a position to comment on your experience and performance during the previous three years.</i>		
Name		
Position		
Telephone number:		
Fax number:		
Mobile:		
Email address:		
Profession		

AGREEMENT

AS A SHARED MATERNITY CARE PROVIDER PARTNER OF JOONDALUP HEALTH CAMPUS, I AGREE TO ALL OF THE FOLLOWING UNDERTAKINGS:

- I will review the hospital's guidelines for shared maternity care available via the hospital website.
- I will observe hospital guidelines in respect of mutual patients, including criteria for hospital review/referral and sharing investigation results and management.
- A copy of this form will be readily available at my practice for administration and other staff.
- I will participate in appropriate continuing professional development for the provision of shared maternity care.
- I will ensure the hospital has up to date preferred contact information (telephone, fax, postal address).
- I will ensure the fax 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 Medical Registration is current and without conditions and I will notify the hospital 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 handheld record.
- I will make appropriate arrangements for continuing care within my practice or with the hospital when I am on leave or ill.
- I acknowledge the hospital may conduct research activities and quality assurance programs and that Shared Maternity Care Partners or patient participation may be requested.
- I authorise the hospital to discuss details of my provision of shared maternity care within the hospital.
- I authorise the hospital 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 hospital (unless employed by the health service to provide intrapartum care).
- I understand that Shared Maternity Care Partners found not to be adhering to guidelines and acceptable standards for quality of care may have their status reviewed and revoked.
- For general practitioners, I confirm that I undertake shared maternity care with the hospital whilst working from a practice accredited against the RACGP Standards for general practice and will inform the hospital if I am no longer working at a practice that is currently accredited against the RACGP Standards for General Practice.
- **APPLICATIONS WILL NOT BE PROCESSED WITHOUT COPIES OF ALL SUPPORTING DOCUMENTS**

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

NAME _____ **SIGNATURE** _____

DATE _____