SA Health Allied Health Professional (AHP)
Re-Credentialing Application

This form is to be used by **allied and scientific health professionals employed by SA Health who have been previously credentialed** in accordance with the Authenticating Allied Health Professionals Credentials Policy Directive (including registered, self-regulated and relevant unregulated professions).

PART 1 – APPLICANT DETAILS

Title : _____ **SA Health Employee: YES**

Surname: _____ **First Name:** _____

Middle Name/s: _____ **Previous Name/s:**_____

Date of Birth: _____ / _____ / _____ **Gender:** _____

Email: _____ **Phone:** _____

Job Title & Profession: _____

Site & Health Unit /Clinical Service: _____

Have you previously been credentialed within a Local Health Network (LHN)/Clinical Service of SA Health?

☐ Yes – specify: _____ ☐ No – *do not use this form. Complete Initial Application.*

REQUESTED LHNS FOR CREDENTIALING

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

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

A. REGISTERED PROFESSION

Profession: _____

Registration Number: _____ Expiry Date: / /

Registration Type: _____

Conditions: ☐ No ☐ Yes If yes, please specify: _____

Do you hold AHPRA endorsement in a specific area of practice?

☐ No ☐ Yes – if yes, please specify_____

Evidence of participation in Continuing Professional Development (CPD) to the level required by your registration type: ☐ Attached

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:

_____

Do you undertake this advanced or extended scope in your current role?

☐ No ☐ Yes – if yes, manager must approve for current role

Medical Radiation Professions Only: LSPN: _____

EPA radiation licence number: _____ Expiry Date: / /

Manager Sign Off

☐ Registration (+/- endorsement) details sighted on AHPRA website

Date sighted:

☐ Evidence of CPD received

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

☐ Licence details sighted

Date sighted:

B. SELF-REGULATED PROFESSION

Manager Sign Off

Profession: _____

Evidence of primary and/or postgraduate qualification from an accredited/ recognised university training program ☐ held on CSCPS ☐ attached

Professional Association: _____

Eligible for Membership ☐ Yes ☐ No

Are there any restrictions or special conditions placed on your professional association membership/eligibility? ☐ Yes ☐ No

If yes, please specify: _____

Do you hold formal Accreditation? ☐ Yes ☐ No

If yes, please specify accrediting body, type/title, number & date of expiry of accreditation: _____

_____

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 ☐

Confirmation of appropriate recency of practice for the profession and role to be undertaken (recent SA Health role or CV or referee checks) ☐

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:

_____

Do you undertake this advanced or extended scope in your current role?

☐ No ☐ Yes *(if yes, manager must approve for current role)*

Qualification confirmed:

☐ on CSCPS *OR*

☐ original provided

☐ Eligibility for membership confirmed

☐ Evidence of accreditation sighted

Date sighted:

☐ Evidence of CPD received

☐ Appropriate recency of practice confirmed

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

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. UNREGULATED PROFESSION

Manager 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

PART 3 - NATIONAL CRIMINAL HISTORY SCREENING	Manager sign off
The 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 line manager as to what checks are required for the role(s). Please review the Criminal and Relevant History Screening Policy to confirm the timeframe within which each type of check must be issued.	
Complete details for all criminal history checks you hold. **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: OR ☐ N/A (if service does not require renewal of criminal history screening or previous screenings remain in-date)

PART 4 – MONITORING CLINICIAN PERFORMANCE	Manager sign off
Under the National Safety & Quality Healthcare Standards (Version 2), SA Health is required to monitor clinicians' performance to ensure the delivery of safe, quality care in all health services. This monitoring is undertaken via a number of clinical governance policies and procedures, including but not limited to requirements under the Clinical Supervision Framework and Performance Review & Development policies.	
CLINICAL SUPERVISION	
Consistent with the SA Health Clinical Supervision Framework, I receive regular clinical supervision from a suitably qualified and experienced allied health professional. Date of most recent session: / /	☐ Regular participation confirmed (via discussion with supervisor or review of supervision log)
PERFORMANCE REVIEW AND DEVELOPMENT (PR&D)	
I participate in six-monthly PR&D process, consistent with the SA Health Performance Review & Development (PR&D) Policy Directive. ☐ Confirmed	Date of last PR&D:

PART 5 – 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 my professional discipline manager or senior allied health professional to seek information relating to my credentials and experience as relevant to my application.

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

Signature: _____ Date: / /

PART 6 - DECLARATION BY PROFESSION MANAGER / SENIOR AHP

I am satisfied that the applicant has the appropriate credentials to undertake the position for which they are being employed 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 Manager/Senior AHP)*
Credentialing Expiry Date:	**/ /**	

*If scope of clinical practice includes Advanced or Extended Scope of practice, 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 the signed credentialing application.

All details from this form, along with a copy of the application form and transcript/parchment of relevant qualifications for self-regulated professions and CV 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 also be submitted to HR/kept on secure file by Manager as per local procedures. Original criminal history clearance documents 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:		