SA Health Allied Health Professional (AHP)
Mutual Recognition of Credentials Application

This form is for use by **allied and scientific health professionals who have current credentialing approval in SA Health (either employed by SA Health, or non-employees with a current Access Appointment)** to request mutual recognition of approval in additional LHNs/Clinical Services, in accordance with the Authenticating Allied Health Professionals Credentials Policy Directive.

Mutual recognition acknowledges that the primary Local Health Network (LHN)/Statewide Clinical Service has approved the credentials of the AHP and an appropriate delegate has sighted and confirmed the necessary supporting documentation. **Supporting documentation/evidence of credentials does not need to be resubmitted as part of the mutual recognition application.**

PART 1 – APPLICANT DETAILS

Surname: _____ **First Name:** _____

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

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

Email: _____ **Phone:** _____

Job Title & Profession: _____

Health Unit or Clinical Service: _____

Work Address: _____

LHN/Clinical Service that granted primary credentialing approval: _____

Primary credentialing approval expiry date: _____ / _____ / _____

REQUESTED LHNS FOR MUTUAL RECOGNITION OF CREDENTIALING

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

PART 2 – PROFESSION & SCOPE OF CLINICAL PRACTICE

Profession: _____

Approved Scope of Practice in primary LHN:

☐ Standard (*scope of clinical practice is Profession as listed above*)

☐ Advanced Scope – please specify training/qualification and scope:

_____

☐ Extended Scope – please specify training/qualification and scope:

_____

Requested Scope of Practice for secondary LHN:

☐ As per primary LHN

☐ Specific to secondary LHN – *please specify training/qualification and scope and provide supporting documentation to allied health manager/senior AHP*

_____

_____

Are there any limitations/restrictions on your practice?

☐ No ☐ Yes – please specify _____

Manager Sign Off

Scope of practice confirmed:

☐ **As per primary LHN**

OR

☐ **Specific to secondary LHN:**

☐ Standard scope of practice (profession)
OR

☐ Advanced scope of practice as specified
OR

☐ Extended scope of practice as specified

PART 3 - NATIONAL CRIMINAL HISTORY SCREENING	Manager Sign Off
Type of criminal history check(s) required is based on the nature of the work undertaken & the patient/client type. Applicants should confirm with line manager/key contact in each LHN as to what checks are required. Please review the Criminal and Relevant History Screening Policy to confirm the timeframe within which each type of check must be issued. *Complete details below for all criminal history screenings you hold.* *Provide supporting documentation for additional checks not previously confirmed/ sighted during the primary LHN credentialing process.*	
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: _____	☐ Details confirmed on CSCPS Database AND/OR ☐ Additional checks sighted Check type sighted: _____ _____ _____ Date sighted: / /

PART 4 – 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 5 - DECLARATION BY PROFESSION MANAGER / SENIOR AHP

I have reviewed the above application and confirmed the primary credentialing approval via the SA Health Credentialing and Scope of Clinical Practice System for Health Practitioners (CSCPS).

Primary Credentialing Approval

Granted in _____ (specify LHN/ Statewide Clinical Service)

Expiry Date: / /

I am satisfied that the applicant has the appropriate credentials to undertake the position for which they are being engaged in the secondary LHN.

Secondary LHN Approval (Mutual Recognition Approval)

Granted in _____ (specify LHN/ Statewide Clinical Service)

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 Mutual Recognition Approval *(Date signed by Manager/Senior AHP)*	/ /
Credentialing Expiry Date: *(as per primary LHN approval)*	/ /

*If identified 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:		