The following categories of allied health professionals are to complete the application process for re-credentialing.

1. **Registered Professionals** must satisfy the requirements of a Registration Board to practise clinically or provide clinical supervision (even if this is infrequent or a small proportion of the role). As at July 2010 these include: Dental Hygiene, Therapy and Prosthetics, Occupational Therapy, Pharmacy, Physiotherapy, Podiatry, Psychology.

2. **Self Regulated Professionals** hold a qualification from an accredited University training program providing eligibility for membership of a Professional Association. As at July 2010 these include: Art Therapy, Audiology, Dietetics, Exercise Physiology, Medical Radiation (including Radiography, Sonography, Radiation Therapy and Nuclear Medicine), Music Therapy, Orthotics and Prosthetics, Social Work, Speech Pathology.

3. **Staff employed under a Grandparent Clause** do not hold a qualification listed in the Commissioner’s Standard for the Allied Health Professional (AHP) classification stream but are classified under this stream in the SA Government Wages Parity (salaried) Enterprise Agreement by virtue of an industrial agreement, on a present position, present incumbent only basis.
PART 1 – APPLICANT’S DETAILS

**DATE of re-Credentialing Application**
/ /  

Note: The duration of the credentialing approval is one year, subject to satisfactory renewal of Registration where appropriate, or lesser time as determined by the Allied Health Discipline Manager/Senior Allied Health Professional.

**NAME:**  Last Name: ___________________________   First Name: ___________________________________
Middle Name/s:  ______________________________

**DATE OF BIRTH:** / /

**HEALTH UNIT AND WORK ADDRESS:** __________________________________________________________
___________________________________________________ ________________________________________

**PRIVATE POSTAL ADDRESS:** __________________________ _______________________________________

**CONTACT DETAILS:**  Work Phone:  ___________________ Mobile:_____________________________
Email:  ___________________________________________ __________________________________________

**PROFESSION DETAILS** *(refer to descriptions above):*

- [ ] Registered
  - Profession: __________________________________________
  - Registration Number:______________________________ Expiry Date: / /
  - Registration certificate attached  

- [ ] Self-Regulated
  - Profession: __________________________________________
  - Membership No. (if relevant): ______________________________
  - Accredited:  No  Yes (please specify): ___________________________

- [ ] Staff employed under a Grandparent Clause
  - Profession: __________________________________________

**CURRENT PRACTISING STATUS:**
Does your role include any clinical responsibilities (eg provision of client services, clinical supervision or clinical governance?)
[ ] Yes  [ ] No

**PREVIOUSLY CREDENTIALED:**
Date of previous credentialing application? / /
Name of SA Health LHN/Clinical Service where previously credentialed: ________________________________
___________________________________________________ _____________________

**NON-AUSTRALIAN RESIDENTS ONLY:**
Do you require a Work Visa to practise in Australia?
[ ] Yes, attached  [ ] No
### PART 2 – SCOPE OF ADVANCED/EXTENDED CLINICAL PRACTICE

List any formal qualifications and competency-based training completed since initial credentialing of advanced or extended practice that you are qualified/credentialled to perform (attach original or certified copies of qualifications).

<table>
<thead>
<tr>
<th>Advanced areas of practice</th>
<th>Qualification/training completed</th>
<th>Date completed</th>
<th>Attached</th>
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</thead>
<tbody>
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### PART 3 – SKILL MAINTENANCE IN ADVANCED/EXTENDED ROLES

Where applicable provide evidence of completion of sufficient procedures to maintain skills in advanced or extended roles.

<table>
<thead>
<tr>
<th>Advanced areas of practice</th>
<th>Skill maintenance</th>
<th>Date completed</th>
<th>Attached</th>
</tr>
</thead>
<tbody>
<tr>
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### PART 4 – CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Evidence of CPD completed within the last year:
- Self-managed portfolio of professional development or
- CPD program points achieved in Professional Association CPD/accreditation program.

Copy of Performance Review and Development Plan completed within last 12 months

### PART 5 – CONFIDENTIAL PROFESSIONAL INFORMATION (self regulating professions and staff employed under a grandparent clause only)

- Have there been any changes to your accreditation/professional association membership status in the past 12 months? □ Yes □ No
- Are there any restrictions or special conditions placed on your professional association membership? □ Yes □ No
- Have any claims, investigation or lawsuits for malpractice been made against you? □ Yes □ No
- Has your scope of clinical practice and/or appointment at any health service been reduced, suspended or revoked? □ Yes □ No
- Is there any other information regarding your ability to practise that should be declared? □ Yes □ No

If yes to any of the above, please attach details. □
PART 6 – PROFESSIONAL SUPERVISION ARRANGEMENT

It is highly desirable for all allied health professionals to access regular clinical supervision\(^1\).

For staff employed under a grandparent clause supervision is provided by an experienced clinician from a suitably aligned registered or self-regulating allied health profession.

For a clinician who is the most senior in his/her work unit, it is expected that supervision will be undertaken with a peer at the same or higher classification in another Local Health Network/clinical service/external agency.

Do you regularly access professional clinical supervision? □ Yes □ No

Approximate frequency of supervision (eg weekly, monthly etc): ____________________

Name of clinical supervisor: ________________________________

Profession of clinical supervisor: ________________________________

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\(^1\) Professional/clinical supervision means the form of control exercised, and may include guidance and monitoring over other allied health professionals demanding professional judgement including: assessing the application of discipline standards, weighing and discussing professional approaches used, determining professional solutions and verification and validation of results. (Appendix 5 SA Govt. Wages Parity (salaried) Enterprise Agreement 2010)

PART 7 – 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 the information referred to in this application will be held in a central secured repository that is accessed by my professional discipline manager/senior allied health professional or allied health director.

Signature: ________________________________ Date: / / 

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### PART 8 – CONFIRMATION OF CREDENTIALS

<table>
<thead>
<tr>
<th>Registered Professions only:</th>
<th>Confirm</th>
<th>Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration Board registration certificate sighted</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Date of sighting: / / /</td>
<td></td>
<td></td>
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</tbody>
</table>

Has the Registration Board placed any restrictions on practice / registration?

- No: □
- Yes: □

If yes, provide details: ______________________________________________________

<table>
<thead>
<tr>
<th>For Medical Radiation Professions</th>
<th>Confirm</th>
<th>Attached</th>
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</thead>
<tbody>
<tr>
<td>A current EPA radiation licence sighted.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Date of sighting: / / /</td>
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<table>
<thead>
<tr>
<th>Continuing Professional Development:</th>
<th>Confirm</th>
<th>Attached</th>
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<tbody>
<tr>
<td>The applicant has participated in relevant CPD over the past year to maintain and develop professional skills in order to fulfil the requirements of the position in which she/he is employed.</td>
<td>□</td>
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</table>

<table>
<thead>
<tr>
<th>Clinical Supervision:</th>
<th>Confirm</th>
<th>Attached</th>
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</thead>
<tbody>
<tr>
<td>The applicant has received regular clinical supervision from a suitably qualified allied health professional commensurate with his/her level of experience and scope of practice.</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>For staff employed under a grandparent clause, supervision is provided by an experienced clinician from a suitably aligned registered or self-regulating profession.</td>
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</table>

<table>
<thead>
<tr>
<th>Performance Review and Development:</th>
<th>Confirm</th>
<th>Attached</th>
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<tbody>
<tr>
<td>The applicant has participated in the annual Performance Review and Development Process within the last 12 months.</td>
<td>□</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Criminal History Report:</th>
<th>Confirm</th>
<th>Attached</th>
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<tbody>
<tr>
<td>Prescribed positions only (re-screened every three years)</td>
<td>□ N/A</td>
<td>□</td>
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<tr>
<td>Date of issue: / / /</td>
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</table>
PART 9: DECLARATION BY PROFESSIONAL DISCIPLINE MANAGER/SENIOR ALLIED HEALTH PROFESSIONAL

On completion of all the components of the re-credentialing procedure, I am satisfied that the applicant has the appropriate credentials and unrestricted registration to undertake the position for which she/he is currently employed and for any advanced / extended roles performed.

Or

The professional registration board or professional association has placed the following restrictions on the applicant’s scope of practice:

___________________________________________________________________________

___________________________________________________________________________

Date of review: / /

Signature: __________________________ Date: / /

Name of professional discipline manager / senior allied health professional

___________________________________________________________________________

Title and Health Unit

___________________________________________________________________________

DATE FOR RE-CREDENTIALLING: / /

On completion, please provide applicant with a copy of the credentialing application.

The original application and associated documents are to be kept on secure file with data entered in a central repository for annual reporting.