aspenmedical

Initial Application Form

Position Details

Position applied for ______________________________

Preferred Status	FT ❑	PT ❑ Desired hours per week ________	Casual ❑

Personal Details

Title(Dr,Mr,Mrs,Ms) ________ Family Name ____________________ Given Name(s) ____________________

If you have changed your name by marriage or otherwise

Former Family Name ____________________ Former Given Name(s) ____________________

Mobile	Home	Work
____________	____________	____________

Email ______________________________

Residential Address

Postal Address (if different to above)

Preferred method of contact

Email ☐ Post ☐ Mobile ☐ Home ☐ Work ☐

Date of Birth Citizenship

Country of Birth

Do you have a valid driver's license? Yes ☐ No ☐

Do you have any restrictions/allowances on this licence that you feel Aspen Medical should be made aware of?

____

Medical Information

Do you have any medical condition that may restrict your capacity to conduct a full range of services commensurate with your qualifications? Yes ☐ No ☐

Do you have any medical condition that may need a restriction on the locations in which you could safely conduct the full range of services commensurate with your qualifications? Yes ☐ No ☐

***Please note**: If yes, you will be required to undertake a medical assessment prior to being offered any work with Aspen Medical.

****Please note**: Some project sites require all staff to under go a pre-placement medical.

Professional Education and Training List most recent first

- Qualifying Degree, Diploma, Certificate (e.g. PhD, DO, MD, MBBS, BN, BBus etc.)
- Post Graduate Studies
- Nationally Accredited Training – e.g. Manual Handling / Fire Warden Training / OH&S
- Basic Life Support / Advanced Life Support Training
- EMST/ACLS/APLS
- Evidence of Continuing Professional Development
  (Attach your statement of compliance from a recognised professional organisation (eg. RACGP, RCNA, etc) or detail continuing professional development undertaken over the last 3 years)

***Please Note**: Please attach a copy of your CV and **certified** copies of all qualifications when sending application

Date Completed	Qualification/Course	Institution and Address

Fellowship/Clinical Specialty e.g. Intensive Care, Orthopaedics, Accident & Emergency, etc

Summary of Employment History last 5 years only

Dates	Organisation/Institution	Position Held/Clinical Area

Professional Registration, Licensure or Certification By Government Authority

State or Province	Country	Number	Issue Date	Expiry Date	Gen/Spec Registration

Current Affiliation with Professional Bodies	
Name of Organisation	Date Joined

Malpractice, Licensure, Privileging Action, and Legal History

a. Has your registration, licence or certification to practice health care in any jurisdiction ever been revoked or restricted? If Yes please provide details below

Yes ☐ No ☐

Comments

b. Have you ever had any disciplinary actions noted against your registration? *If Yes please provide details below)*

Yes ☐ No ☐

Comments

Other Information Include any additional relevant information that you wish to bring to our the attention

Referees please provide 3 referees, 2 of which need to be work referees

Name	Position	Contact (BH)

Acknowledgment and Signatory Block of Applicant

☐ I acknowledge that the information provided by me in this form is true and correct and I hereby give permission for Aspen Medical to contact my referees with respect to this application.

Signature	Name	Date

OFFICE USE

The undersigned confirms the information provided by ……………………………………….related to education and training, licensure, and current employment status.

Verified in accordance with para 16 of DI(G) ADMIN 24-5 Yes No
Expiry date of applicants Annual Practicing or Registration Certificate

EXPIRY DATE:

Credentialed By:

Signature	**Printed name**	**Rank or Title**	**Date**

Recommended Position(s):	**GP** **AME GP** **Anaesthetist** **Surgeon**	**Other ………………………………………**