



QUAY PARK
Surgical Centre

Attending Medical or Dental Practitioner
CREDENTIALING APPLICATION FORM

- ☐ Surname:
- ☐ Christian or given names
- ☐ Date of Birth
- ☐ Dental or Medical Council No

CONTACT DETAILS

- ☐ Address (consulting rooms)
- ☐ Postal address
- ☐ Phone ☐ Fax ☐ Mobile
- ☐ Website ☐ Email
- ☐ Residential address.....

QUALIFICATIONS

- ☐ Graduated ☐ University
- ☐ Degree/s and qualifications (specialty)
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SPECIAL INTEREST AREAS

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HOSPITAL EXPERIENCE

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CURRENT HOSPITAL APPOINTMENTS.....

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PROFESSIONAL ASSOCIATIONS.....

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REASON FOR APPLICATION (Brief detail of scope of intended practice)

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REFERENCES

(Details of three persons who could be approached as references. Referees must currently be in clinical practice)

☐ Name ☐ Phone

☐ Address.....

☐ Name ☐ Phone

☐ Address.....

☐ Name ☐ Phone

HOSPITAL EXPERIENCE

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CURRENT HOSPITAL APPOINTMENTS.....

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☐ **Signature of applicant** ☐ **Date**.....

IMPORTANT—Please remember to include the following

- ☐ Curriculum vitae
- ☐ Copy of current Annual Practising Certificate
- ☐ Copy of Indemnity insurance (Medical Protection Society)
- ☐ Evidence of Continuing Professional Development Programme
- ☐ And/or confirmation that you have been credentialed by a Public Hospital, your Scope of Practice and the date you are credentialed to.

When completed be sent the above mentioned documentation to

Hospital Manager
Quay Park Surgical Centre
P.O Box 74 504
Greenlane Auckland 1546