



**Shared Maternity Care Affiliate Reaccreditation Application Form**  
 for the triennium 1 January 2011 – 31 December 2013  
 For GPs and Obstetricians

<b>Surname</b>	
<b>Given name</b>	
<b>Middle names</b>	
<b>Email address</b>	
<b>Preferred mailing address</b>	

**Practice details:**    **As above**  **yes**                       **no (please complete below)**

1) \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Provider number: \_\_\_\_\_ Fax: \_\_\_\_\_

2) \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Provider number: \_\_\_\_\_ Fax: \_\_\_\_\_

**QA&CPD No.:** \_\_\_\_\_

- Female                       Male  
 General Practitioner     Obstetrician                       FRACGP

Languages spoken (other than English): \_\_\_\_\_

**I wish to apply for reaccreditation as a Shared Maternity Care Affiliate at (*please tick one or more of*):**

- Mercy Hospital for Women     Northern Health (The Northern Hospital)  
 The Royal Women's Hospital     Western Health

Office Use Only:    Date received: ___/___/___	Processing hospital: MHW / RW / NH / WH
Approved date: ___/___/___	<input type="checkbox"/> Copy to SMCC
Approved signature _____	Approved Name: _____

## PROFESSIONAL REQUIREMENTS

A. All applicants for Shared Maternity Care Affiliate reaccreditation must provide evidence of:

- Current Unrestricted Medical Registration in Victoria: **Please attach copy of Medical Board Registration**
- Current Medical Indemnity Insurance membership: **Please attach copy of Medical Indemnity Insurance**

You are advised to ensure that your medical indemnity covers the provision of shared maternity care.

B. All applicants for Shared Maternity Care Affiliate reaccreditation must have completed **at least one of the following activities in the 2008-2010 triennium** (please indicate which activity has been undertaken):

### For GPs

- Accreditation as a Shared Maternity Care Affiliate after 1 January 2010**  
*All other sections of this application form must be completed*
- 2008, 2009 or 2010 annual half day Shared Maternity Care Workshop run by Mercy Hospital for Women, Northern Health, The Royal Women's Hospital and Western Health**  
*A photocopy of attendance certificate or RACGP CPD statement must be attached*
- RACGP CPD Activities**  
10 RACGP Category 2 CPD points from activities directly related to **pregnancy care, pre pregnancy care, postnatal period and neonatal CPD activities**.  
*As pregnancy points are not an RACGP category GPLOs will adjudicate each application. Therefore details of topics and a photocopy of attendance certificate or RACGP CPD statements must be attached*
- Supervised Antenatal Session** (exclusive of clinic attendances for initial accreditation)  
One clinical update antenatal session at any of the four hospital sites or their community clinics. *Please attach evidence*
- Alternative Activities**  
You are invited to submit continuing professional development activities directly related to **pregnancy care, pre pregnancy care, postnatal period and neonatal equivalent to 10 Group 2 RACGP points** for consideration. You may consider developing your own small group learning module within a practice.  
*Please detail (e.g. date, activity, organising body, time taken, venue):*

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### For Obstetricians

- I am a Fellow of RANZCOG**  
Current Fellowship will be confirmed by the hospitals with RANZCOG in late 2010



### C. AGREEMENT

**As a Shared Maternity Care Affiliate of Mercy Hospital for Women, The Royal Women's Hospital, Western Health and Northern Health, I agree to all of the following undertakings:**

- I will review the guidelines the 'Guidelines for Shared Maternity Care/Shared Maternity Care Affiliates, 2010' available via hospital websites after December 2010
- I will observe hospital guidelines in respect of mutual patients, including criteria for hospital review/referral
- I will participate in appropriate continuing professional development for the provision of shared maternity care
- I will ensure the Shared Maternity Care Coordinators have up to date preferred contact information (telephone, facsimile, postal address)
- I will ensure the facsimile number given applies to a machine that is in a private location and procedures for handling patient information comply with privacy principles and legislation
- My Medical Registration is current and without conditions and I will notify the General Practice Liaison Units if my registration is suspended, cancelled or has restrictions imposed
- My Medical Indemnity Insurance will be maintained at an adequate level of cover for the duration of my participation in shared maternity care
- I will keep appropriate clinical records
- I will make appropriate arrangements for continuing care with an accredited Shared Maternity Care Affiliate or the hospital where the woman is booked for birth when I am on leave or ill
- I acknowledge the hospitals conduct research activities and quality assurance programs and that Shared Maternity Care Affiliate or patient participation may be requested
- I authorise the hospitals and their General Practice Liaison Units to discuss details of my provision of shared maternity care, both within the hospitals and between hospitals
- I authorise the hospitals to exchange details about my accreditation, including contact details
- I authorise the hospitals to publicly publish and provide women and their families with my practice details, areas of interest and languages spoken

**NB: Applications will not be processed without copies of all supporting documentation.**

I confirm the indicated activities in section B are true and accurate and agree to the undertakings listed in this agreement (section C).

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### Checklist

- Attach copy of Medical Board Registration
- Attach copy of Medical Indemnity Insurance
- Evidence of CPD
- Signature



If you do not wish to continue as a shared maternity care affiliate please indicate.

- I do not wish to reaccredit as a Shared Maternity Care Affiliate ( in which case your name will be removed from the register/s)

Name:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please sign and return this form and copies of the relevant documentation by  
**POST before 31 October 2010 to:**

**The Royal Women's Hospital**  
Shared Maternity Care Coordinator  
The Royal Women's Hospital  
Cnr Flemington Rd & Grattan St  
Parkville VIC 3052

**Enquiries:**

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