Antenatal Shared Care (ANSC) Program
REGISTRATION APPLICATION FORM

Details: General Practitioner

Surname:_____ Given Name:_____

❑ Male ❑ Female Date of Birth: _____ RACGP QACPD No:_____

Please list any languages, other than English which you speak fluently and would be willing to conduct ANSC consultations: _____

Are you **only** willing to accept ANSC referrals for patients who normally attend your practice? ❑ Yes ❑ No

Practice Details: (*where you conduct most consultations):*

Practice Name:_____

Practice Ph: _____ Practice Fax: _____ Mobile: _____

Email: *(to receive CESPHN ANSC correspondence)* _____

Practice Street Address:_____

_____ Post Code: _____

Practice Postal Address (*if different from above):* _____

_____ Post Code: _____

***Additional Locations** (if applicable)*

Practice Name:_____

Practice Ph: _____ Practice Fax: _____

Practice Street Address:_____

_____ Post Code: _____

Antenatal Shared Care experience:

Please detail previous hospital experience relating to antenatal shared care **with particular focus on the management of low to medium risk pregnant women**

_____

_____

_____

_____

_____

List any other hospitals where you are presently Recognised/Affiliated to provide antenatal shared care

_____

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PLEASE SUBMIT COPIES OF THE FOLLOWING DOCUMENTS UNLESS OTHERWISE NOTED

Required Documentation	***RHW ANSC (Office Use Only)***
RHW Application form	
Fellowship of the College of General Practitioners or Vocational registration with commitment to CPD (commencement of each triennium);	
Current APHRA registration (commencement of each triennium & annual to PHN) Expiry Date: _____	
Current Medical Indemnity (commencement of each triennium & annual to PHN); Expiry Date: _____	
100 point ID check ***NB: RHW Staff are required to sight applicant's original identifying documents as per 100 point ID check and retain copies of identification documents***	
Evidence of completion of College CPD requirements for renewal or cross affiliation (**12 ANSC CPD Points** during each triennium or pro-rata). ***THIS DOES NOT APPLY TO NEW REGISTRATIONS***.	
Immunisation Health record;	
Working with Children Check;	
National Criminal Record Check Consent form.	

PLEASE NOTE: COMPLETING THIS FORM DOES NOT GUARANTEE ACCREDITATION TO THE ANTENATAL SHARED CARE PROGRAM

Agreement:

If accepted, I agree to:

1. adhere to the current ANSC protocols and policies;
2. meet the ongoing educational requirements;
3. maintain my Medical Registration; and
4. maintain my Medical Indemnity insurance.

Signature: _____ Date: _____

Consent to Release of GP Information

As part of the Antenatal Shared Care Program, the Central and Eastern Sydney PHN collects GP information (including: name, practice address, phone, fax, gender, and languages spoken). This information is forwarded to the Antenatal Clinics to facilitate GP participation in the program.

The National Privacy Principles and the Privacy Act prohibit us from releasing this information without your prior consent. In order to assist us in the process of maintaining your confidentiality, please complete and return this document.

I authorise Central and Eastern Sydney PHN Antenatal Shared Care Program to release my personal details, as listed above, to the participating Hospitals.

Signature: _____ Date: _____

Name (*print in block letter):* _____

Please contact Julie Davis (Antenatal Outpatients Department, The Royal Hospital for Women) on PH: 9382 6016 (Monday & Tuesday) to arrange a convenient time for document verification.

RHW Antenatal Shared Care (Office Use only)

Application Received _____ / _____/ _____	ANSC Intake Session _____ / _____/ _____	Database entry _____ / _____/ _____
Appointment Letter _____ / _____/ _____	GP Liaison Midwife notified _____ / _____/ _____	