**STATEWIDE EQUIPMENT PROGRAM**

**EXPRESSION OF INTEREST**

**FOR APPOINTMENT AS A CLINICAL ADVISOR –**

**Oxygen (Paediatrics)**

Please refer to the SWEP clinical advisor roles and responsibilities document, for information relating to the position

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Clinician details** | | | | | | | | | |
| **Name** | | | **Given names** | |  | **Surname** | |  | |
| **Residential address** | | |  | | | | | | |
| **State** | | |  | | **Post Code** |  | | | |
| **Email address** | | |  | | | | | | |
| **Telephone number** | | | **Business:** | |  | **Private:** | |  | |
| **Please state your profession** | | | | |  | | | | |
| 1. **Scope of practice/ area of expertise** | | | | | | | | | |
| **Please indicate your chosen scope of practice/ area of expertise as it relates to the following consumer attributes and home oxygen items for children** (choose all that apply) | | | | | | | | | |
| **Consumer attributes** | | | | | **Items** | | | | |
| Palliative  Broncho-Pulmonary Dysplasia **WITH** any of the following  Pulmonary Hypertension **OR**  Congenital Lung Disease **OR**  End stage Lung Disease **OR**  Non-Invasive Ventilation (NIV) **OR**  Requires > 0.5 lpm supplemental O2  Other complex consumers (please specify) | | | | | Portable oxygen cylinders for consumers  Portable oxygen concentrators for consumers  Oxygen concentrators for flow rates >5 lpm  Other (please specify) | | | | |
| 1. **Professional qualifications**   (\*please attach evidence and include certified copies of original qualifications) | | | | | | | | | |
| **Qualification** | | | | | **Place Obtained** | | | | **Date** |
|  | | | | |  | | | |  |
|  | | | | |  | | | |  |
|  | | | | |  | | | |  |
|  | | | | |  | | | |  |
| Registrations, memberships, certifications, and accreditations (indicate all that apply) | | | | | | | | | |
| **AHPRA registration number** (all applicants must supply number here)  (Must be a Specialist Paediatric Respiratory and Sleep Medicine Physician) | | | | | | |  | | |
| **Other relevant (State name)**  (If applicable \*please attach evidence) | | | | | | |  | | |
| Current Working with Children Check (employee) (\*please attach copy of the card) | | | | | | | | | |
| **Name on card** | | | | |  | | | | |
| **Card number** | | | | |  | | | | |
| **Expiry date** | | | | |  | | | | |
| Current Satisfactory Police Check (no more than 1 year old)(\*please attach copy) | | | | | | | | | |
| This need not be supplied at the time of application if you do not have a current check.  Do you agree to undertake a police check at your own expense if you are the preferred candidate? Appointment will be subject to this being clear.  YES  NO | | | | | | | | | |
| Current Professional indemnity Insurance (required)(\*please attach evidence of your certificate) | | | | | | | | | |
| This does not need to be supplied at the time of application, if you do not have current Professional Indemnity Insurance.  Do you agree to obtain this at your own expense if you are the preferred candidate? Appointment will be subject to this being in place.  YES  NO | | | | | | | | | |
| **Name of Insurer** | | | | |  | | | | |
| **Type of insurance** | | | | |  | | | | |
| **Expiry date** | | | | |  | | | | |
| 1. **COVID 19 vaccination status**   (\*please attach evidence) | | | | | | | | | |
| The Clinical Advisor must be able to demonstrate evidence of COVID-19 vaccination status or exemption in accordance with the Victorian Government worker vaccination requirements for healthcare workers - <https://www.coronavirus.vic.gov.au/worker-vaccination-requirements> | | | | | | | | | |
| 1. **Current employer(s) and role** | | | | | | | | | |
| **Name of current employer 1** | | | | |  | | | | |
| **Title/role** (Grade if applicable) | | | | |  | | | | |
| **Period and type of employment** (how many days per week? date employed from and to?) | | | | |  | | | | |
| **Name of current employer 2** (if applicable) | | | | |  | | | | |
| **Title/ role** (Grade if applicable) | | | | |  | | | | |
| **Period and type of employment** (how many days per week? date employed from and to?) | | | | |  | | | | |
| **Additional current employer** (add details) | | | | |  | | | | |
| 1. **Publications/ Presentations**   Please list publications and relevant presentations (state / national/ international level highly regarded) | | | | | | | | | |
|  | | | | | | | | | |
| 1. **Continuing professional development**   Please list the continuing professional development you have participated in the past 2-3 years, particularly those that are relevant to your expertise in prescribing domiciliary supplemental long-term Oxygen for Children | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
| 1. **Clinical review / Quality Assurance**   Please indicate your knowledge and experience in the fields of | | | | | | | | | |
| 1. Clinical Audit | | | | | | | | | |
| 1. Professional credentialing and defining scope of practice | | | | | | | | | |
| 1. Education and In-service | | | | | | | | | |
| 1. Customer Service (including complaints management) | | | | | | | | | |
| 1. Other (please specify) | | | | | | | | | |
| 1. **Summary of related experience**   Please provide a detailed summary of experience in prescribing domiciliary supplemental long-term oxygen therapy for Children - include details of;   * roles in areas such as related Special Interest Groups, Professional leadership positions etc. * AND number years of experience (after registration to practise with Ahpra as a Specialist Paediatric Respiratory and Sleep Medicine Physician * AND current or past experience in a Level 41 (or higher) nursery | | | | | | | | | |
|  | | | | | | | | | |
| 1. **Referees**   Please provide the names and contact details of two (2) professional referees who can validate the above summary | | | | | | | | | |
| **Name** |  | | | **Contact details** | | |  | | |
| **Name** |  | | | **Contact details** | | |  | | |
| 1. **Availability**   Please indicate your ability to attend meetings (anticipated as full days 1-2 times per year) as well as your future capacity on a consultation basis (please indicate availability, potential responsiveness, etc) | | | | | | | | | |
|  | | | | | | | | | |
| 1. **Declaration** | | | | | | | | | |
| I understand that appointment as a Clinical Advisor to the State-wide Equipment Program will require some intensive consultation as well as a more sporadic consultative role. If appointed I will abide by mutually agreed standards and KPIs.  I have disclosed any current or pending restrictions to rights or capacity to practice.  I have disclosed of any current or pending litigation related to the proposed sphere of practice. | | | | | | | | | |
| **Name** | |  | | | | | | | |
| **Signature** | |  | | | | | | | |
| **Date** | |  | | | | | | | |

***Forward to:***

Donna Markham

Chief Allied Health Officer

State-wide Equipment Program

Ballarat Health Services

PO Box 577

Ballarat     Vic      3353

Email: [swepcaho@bhs.org.au](mailto:swepcaho@bhs.org.au)