**STATEWIDE EQUIPMENT PROGRAM**

**EXPRESSION OF INTEREST**

**FOR APPOINTMENT AS A CLINICAL ADVISOR –**

**Lymphoedema Compression Garment Program**

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

|  |
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| 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**
 |
| **Please indicate your chosen scope of practice as it relates to the Lymphoedema Compression Garment Program** (choose all that apply) |
| [ ]  Head and Neck[ ]  Genital and Abdomen[ ]  Upper limb[ ]  Lower Limb[ ]  Breast and Trunk[ ]  Adults[ ]  Children | **[ ]** Off the shelf garments [ ]  Made to measure garments[ ]  Wraps[ ]  Wound care[ ]  Providing initial diagnostic assessment, ongoing assessment, and treatment of people with lymphoedema[ ]  Provide ongoing assessment and treatment of people with lymphoedema |
| 1. **Professional qualifications and endorsed training (e.g., Australasian Lymphology Association (ALA)**

(\*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 AHPRA registered professions must supply)  |       |
| **[ ]  Australasian Lymphology Association membership** (if applicable \*please attach evidence) |       |
| **[ ]  ALA Accredited Practitioner on the National Lymphoedema Practitioners Register** (if applicable \*please attach evidence) |       |
| **[ ]  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 need not 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. **Current employer(s) and role**
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| **Name of employer 1** |       |
| **Title/role** (Grade if applicable) |       |
| **Period and type of employment** (how many days per week? date employed from and to?) |       |
| **Name of 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 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 relevant categories of aids and equipment/ assistive technology |
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| 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 the area of expertise nominated on this form |
|       |
| 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 Statewide 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

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