Health
Sydney
Local Health District

phn
CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

Antenatal Shared Care (ANSC) Program

REGISTRATION APPLICATION FORM

1. Details: **General Practitioner** ❑ Yes **Registrar** ❑ Yes

Surname: _____ Given Name: _____

❑ Male ❑ Female Date of Birth: _____ RACGP QI&CPD 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 ❑

2. Practice Details: **Primary Location** (*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: _____

3. 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

_____

4. Qualifications: ❑ DRANZCOG date _ /_ /_ ❑ Other, please specific _____

5. AHPRA Medical Registration: *(please include a copy)* Registration Number: MED _____

6. Medical Indemnity Insurance: *(please include a copy)*

Name of organisation: _____Registration Number: _____

Are you appropriately indemnified with the right level of cover? ❑ Yes ❑ No

7. Agreement:

If accepted, I agree to:

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

Signature: _____ Date: _____

8. 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.

Signed: _____ **Date:** _____

Name (*print in block letter):* _____

I give permission to be listed on the CESPHN website as a *Recognised ANSC GP*. My details listed will included name, practice address, practice phone, practice fax, gender and languages spoken Yes ❑ No ❑

Signed: _____

Please sign and return this form and copies of relevant documentation to:
Maternal Health Project Officer Attention: Karen Wheeler Level 5, 201 Coward St MASCOT NSW 2020
Ph: 1300 986 991 Fax: 1300 110 917 Email: k.wheeler@cesphn.com.au

Antenatal Shared Care (Office Use only)

Application Received _ / _ / _ Orientation Session Attended ☐ _ / _ / _
Database entry ☐ Appointment Letter ☐ _ / _ / _ GP Liaison Midwife notified ☐