Antenatal Shared Care (ANSC) Program
REGISTRATION APPLICATION FORM

Details: **General Practitioner (VR)** ❑ Yes **General Practitioner (non-VR)** ❑ Yes

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 use 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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Qualifications (optional):

❑ DRANZCOG date _ /_ /_ ❑ Other, please specify _____

AHPRA Medical Registration: *(please attach a copy)* Registration Number: MED _____

Medical Indemnity Insurance: *(please attach a copy)*

Name of organisation: _____Registration Number: _____

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

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 letters):* _____

I give permission to be listed on the CESPHN website as an affiliated ANSC GP. My details listed will include name, practice address, phone, fax, gender and languages spoken. Yes ☐ No ☐

Signature: _____Date: _____

Please sign and return this form, plus copies of relevant documents to:
Attention: Maternal and Child Health Program Officer
Email: ansc@cesphn.com.au (preferred)
Fax: 1300 110 917