RAMSAY HEALTH CARE AUSTRALIA PTY LIMITED
ABN 36 003 184 889

St George Private Hospital
1 South Street, Kogarah NSW 2217
Ph: 02 9598 5421 Fax: 02 9598 5433

Application for Appointment as an Accredited Practitioner

Practitioner Accreditation Application Form

St George Private Hospital, Kogarah

Thank you for lodging your application for accreditation at St George Private Hospital.

St George Private Hospital is a 236 bed acute Surgical and Medical facility with a Level 2 ICU, Level 2 Special Care Nursery, 6 bed Delivery Suite, 19 bed Day Surgery Facility, an Interventional Cardiac Catheter Laboratory, 12 Operating Theatre complex and 3 Endoscopy and minor procedure rooms.

This application has been designed based on the clinical scope undertaken at St George Private, and your application will be considered and processed on this basis.

If you are requesting a scope of practice beyond the options detailed on pages 4, 5 and 6, you will need to discuss this with the CEO before you lodge your application to ensure the Hospital has the appropriate resources to manage your patient requirements.

Any queries or questions regarding this application should be lodged to:

Chief Executive Officer
St George Private Hospital
1 South Street
Kogarah NSW 2217

Ph: 02 9598 5421
Fax: 02 9598 5433
Email: revies@ramsayhealth.com.au

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St George Private Hospital

Application for Appointment as an Accredited Practitioner

Application for Appointment as an Accredited Practitioner

I hereby apply to Ramsay Health Care for Appointment as an Accredited Practitioner at **St George Private Hospital** and seek appointment for the category and privileges indicated. To support my application I submit the following information. (**Please Print** and attach separate sheets if insufficient space):

1. Personal Details

Title (eg: Dr, Mr, A/Prof, Prof)			
Surname:			
Given Name(s):			
Any former names (including maiden name)		**Prescriber No.:**	
		Provider No.:	

Practice Address:			
	Postcode:		
Telephone:		**Facsimile:**	

Residential Address:			
	Postcode:		
Telephone:		**Pager No.:**	
Facsimile:		**Mobile No.:**	
Date of Birth:		**Name of Spouse/Partner:**	Invitation Purposes only
Email:			

Postal Address:	☐ Practice ☐ Residential ☐ Other – details as follows:
	Postcode:

NB: IT IS THE APPLICANT'S RESPONSIBILITY TO ENSURE ANY CHANGES TO CONTACT INFORMATION IS ADVISED TO THE HOSPITAL IMMEDIATELY.

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2. Clinical Privileges & Scope of Practice

Please detail scope of Clinical Practice Requested: (Not applicable for Surgical Assistants)

NB: Applicants must tick the specialty required and then all relevant sub-specialties, privileges are sought in.

Categories	Please tick	**Privileges**	Please tick
Specialist Practitioner *(please attach copy of Medicare Eligibility confirmation letter)*		Admitting Privileges	
Consultant Emeritus (no admitting rights)		Consulting Privileges	
Fellow Practitioner (no admitting rights)		Assist Privileges	
Dentist		Anaesthetic Privileges	
HMO/CMO (no admitting rights)		Surgical/Procedural Privileges	
Surgical Assistant (no admitting rights)		Diagnostic Privileges	
General Practitioner (Surgical Assist only - no admitting rights)		Observer only	
Other		Other	

Surgical Assistants only – who will you be assisting? ____

Type of Appointment Required:	☐Permanent	A Permanent appointment covers up to 12 months to 5 years depending on review and approval by the Credentials Committee
	☐Temporary	A Temporary appointment is for a maximum of up to 4 months only commencing from the date of approval given by the CEO
	☐Fixed Term	A Fixed Term appointment is for a maximum of up to 6 months only and is not continuous beyond this date. Please state the period you require accreditation for: From: _______________________ to ______________________
	☐Locum Tenens	A Locum appointment is for a date, a case or short period of time to cover another doctor. Please state what date/period you require accreditation for and which doctor you will be locuming for: Date(s)___________________ covering Dr: _________________

If you are applying for interventional privileges, such as endovascular, cardiology, radiology and/or laser, advanced endoscopic or laparoscopic surgery, you will need to provide evidence of training and experience as per the relevant College Guidelines for a minimum of 12 months, and copies of licenses, where applicable, such as EPA Radiation License.

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❑ **ANAESTHESIA**
- ❑ Adults
- ❑ Neonatal *(<1yr old in an Emergency situation only)*
- ❑ Obstetric
- ❑ Paediatric *(>1yr old)*
- ❑ Cardiac – Adult only
- ❑ Trans-Oesophageal Echo (TOE) - Adult only
- ❑ Chronic Pain Management

❑ **CARDIAC PERFUSION**

❑ **CARDIOLOGY – SEE APPENDIX A**

Please complete Competencies contained within Appendix A

❑ **CARDIOTHORACIC SURGERY**

Adult Only
- ❑ Vascular Procedures
- ❑ Coronary Artery Bypass
  - ❑ Off Pump Procedures
  - ❑ Minimally Invasive Surgery
- ❑ Arrhythmia Surgery
- ❑ Thoracic Aorta Procedures
- ❑ Thoracic/Lung Procedures
- ❑ Insertion of Pacemaker
- ❑ Other – Please Specify:

❑ **DENTISTRY**
- ❑ Adults
- ❑ Paediatric

❑ **ENT SURGERY**
- ❑ Adult
- ❑ Paediatric
- ❑ Adenoidectomy
- ❑ Bronchial Procedures
- ❑ Ear Procedures
- ❑ Facial Nerve
- ❑ Laryngeal Procedures
- ❑ Sinonasal Procedures
- ❑ Otolaryngology-Head & Neck
- ❑ Oral & Oropharyngeal Procedures
- ❑ Tonsillectomy
- ❑ Laryngeal & Tracheal Procedures
- ❑ Other – Please Specify:

❑ **GASTROENTEROLOGY**
- ❑ Diagnostic Upper Gastrointestinal Endoscopy
- ❑ Therapeutic Upper Gastrointestinal Endoscopy
- ❑ Liver Biopsy
- ❑ Enteroscopy
- ❑ Sclerotherapy
- ❑ Oesophageal Banding
- ❑ Placement of Oesophageal Prostheses
- ❑ Oesophageal Dilatation
- ❑ Flexible Sigmoidoscopy
- ❑ Diagnostic Colonoscopy
- ❑ Therapeutic Colonoscopy
- ❑ Endoscopic Retrograde Cholangiopancreatography (ERCP) & Associated Therapeutic Interventions & Biliary Stenting
  - ❑ Cholangiogram
- ❑ Percutaneous Endoscopic Gastrostomy (PEG)

❑ **GENERAL SURGERY**
- ❑ Adult
- ❑ Colorectal Surgery
- ❑ Endocrine Surgery
  - ❑ Adrenalectomy
  - ❑ Thyroidectomy
- ❑ Endoscopic Surgery
- ❑ Gastrointestinal Surgery
- ❑ Laparoscopic Surgery
  - ❑ Diagnostic
  - ❑ Interventional
- ❑ Upper GI Surgery

❑ **GENERAL SURGERY - SUBSPECIALTIES**
- ❑ Paediatric
- ❑ Breast Surgery
- ❑ Hepatobiliary & Pancreatic Surgery
- ❑ Oesohagectomy
- ❑ Bariatric Surgery

  Adults & Adolescents (16-18yrs) Only
  - ❑ Lap Banding
  - ❑ Modified Roux-en-Y
  - ❑ Sleeve Gastrectomy

NB: Paediatric Lap Banding is not permitted at this hospital
NB: Scopinaro or Biliopancreatic Bypass is not permitted at this hospital

❑ **GYNAECOLOGY - GENERAL**
- ❑ Advanced Endoscopic Surgery
- ❑ Gynaecology General
- ❑ Laparoscopic Surgery
- ❑ Prolapse Surgery
- ❑ Ultrasound

❑ **GYNAECOLOGY - SUBSPECIALTIES**
- ❑ Assisted Reproductive Services (IVF)
- ❑ Gynaecological Oncology
- ❑ Uro-gynaecology

❑ **INTENSIVE CARE**
- ❑ Adults

❑ **MEDICINE**
- ❑ General Medicine
  - ❑ Adults Only
  - ❑ Dermatology
  - ❑ Endocrinology
  - ❑ Geriatrics
  - ❑ Hepatology
  - ❑ Immunology
  - ❑ Infectious Diseases
  - ❑ Internal Medicine
  - ❑ Neurology
  - ❑ Oncology
    - ❑ Adults Only
    - ❑ Medical Oncology
  - ❑ Radiation Oncology

    Provide copy of EPA License
  - ❑ Palliative Care
  - ❑ Hematology
  - ❑ Rehabilitation
  - ❑ Renal Medicine
    - ❑ Nephrology-General
    - ❑ Nephrology-Interventional
  - ❑ Respiratory Medicine
    - ❑ Bronchoscopy- Diagnostic
    - ❑ Bronchoscopy- Therapeutic
    - ❑ Sleep Medicine
      - o *Adult*
      - o *Paediatric*
  - ❑ Rheumatology
  - ❑ Other – Please specify:

❑ **NEUROSURGERY**

Adult Only
- ❑ Nerve Procedures
- ❑ Spinal Procedures

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- ❑ **OBSTETRICS**
  - ❑ Maternal Fetal Medicine
  - ❑ Obstetrics
  - ❑ Ultrasound
  - ❑ Uro-gynaecology
- ❑ **OPHTHALMOLOGY**
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Cataract Surgery
  - ❑ Corneal Transplantation
  - ❑ Eyelid Surgery
  - ❑ Glaucoma Surgery
  - ❑ Lacrimal surgery
  - ❑ Oculopastic
  - ❑ Orbital Surgery
  - ❑ Pterygium Surgery
  - ❑ Refractive Surgery
  - ❑ Squint Surgery
  - ❑ Vitreoretinal Surgery
- ❑ **ORAL & MAXILLOFACIAL**
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Orthognathic Surgery
  - ❑ Implant/Pre-Prosthetic Surgery
  - ❑ Trauma
  - ❑ TM Joint Surgery
  - ❑ Oncology
- ❑ **ORTHOPAEDICS - GENERAL**
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Arthroscopic Surgery
  - ❑ Fracture Management
  - ❑ Major Joint Replacement
- ❑ **ORTHOPAEDICS - SUBSPECIALTY**
  - ❑ Spinal Surgery
  - ❑ Other – Please Specify
- ❑ **PAEDIATRIC MEDICINE**
  - ❑ General Medicine
  - ❑ Neonatology Level II *(34wks or later)*
  - ❑ Other – Please Specify:
- ❑ **PAEDIATRIC SURGERY**
  - ❑ Other – Please Specify:
- ❑ **PATHOLOGY**

- ❑ **PLASTIC & RECONSTRUCTIVE SURGERY**
  - ❑ Adult
  - ❑ Paediatric
    - ❑ Bat Ears Only
    - ❑ Repair of Lacerations Only
    - ❑ Revision of Scars Only
  - ❑ Abdominal Reductions
  - ❑ Augmentation
  - ❑ Breast Surgery
  - ❑ Cosmetic Rhinoplasty
  - ❑ Endoscopic Brow Surgery
  - ❑ Facial Surgery
  - ❑ Laser Ablation
    Provide copy of EPA License
  - ❑ Liposuction
  - ❑ Neurovascular Flaps
  - ❑ Other – Please Specify:
- ❑ **RADIOLOGY – SEE APPENDIX B**
  - ❑ Diagnostic Imaging
    - ❑ Adult
    - ❑ Paediatric
    - ❑ Bone Mineral Densitometry (BMD)
    - ❑ Computerised Tomography (CT Scan)
    - ❑ Fluoroscopy
    - ❑ Magnetic Resonance Imaging (MRI)
    - ❑ Mammography
    - ❑ Nuclear Medicine
    - ❑ Radiation Oncology
    - ❑ Standard Diagnostic Radiography
    - ❑ Ultrasound
  - ❑ Interventional Radiology
    - ❑ Adult
    - ❑ Paediatric
      - ❑ Diagnostic
        Perform at least 100 procedures/ yr
      - ❑ Interventional
        Perform at least 175 procedures/ yr
      - ❑ Interventional Radiology Service
        - o *Tier A*
        - o *Tier B*

- ❑ **RADIOLOGY – SEE APPENDIX B (Continued)**
  - ❑ Vascular Catheterisation
    - ❑ Diagnostic
    - ❑ Interventional
  - ❑ Nuclear Medicine
    - ❑ Adult
    - ❑ Paediatric
      - ❑ Anatomical Pathology
      - ❑ Conventional Gamma Cameras
      - ❑ Positron Emission Tomography (PET)
- ❑ **UROLOGY**
  - ❑ Adult
  - ❑ Paediatric
    - ❑ Endoscopic Urology
    - ❑ Laparoscopic Urology
    - ❑ Laser
      Provide copy of EPA License
    - ❑ Open Urological Procedures
    - ❑ ESWL
      Provide copy of EPA License
    - ❑ Other – Please Specify:
- ❑ **UROLOGY - SUBSPECIALTY**
  - ❑ Brachytherapy
  - ❑ HiFu
  - ❑ Lithotripsy
  - ❑ Other - Please Specify:
- ❑ **VASCULAR SURGERY**
  - ❑ Anastomosis
  - ❑ Arterial Patch
  - ❑ Bypass
  - ❑ Decompression
  - ❑ Embolectomy
  - ❑ Endarterectomy
  - ❑ Ligation of Aneurysms
  - ❑ Repair
  - ❑ Replacement
  - ❑ Thrombectomy
  - ❑ Vascular Trauma of the following:
  - ❑ Abdominal
    - ❑ Aortic
    - ❑ Mesenteric
    - ❑ Open

❑ VASCULAR SURGERY (continued)			
❑ Axillary, Subclavian ❑ Carotid Procedure - Endoluminal ❑ Carotid Surgery - Open	*Please complete Endovascular Competencies – See Appendix A* ❑ AAA Stent Grafts ❑ Carotid Interventions ❑ Diagnostic Procedures ❑ Embolisation Procedures	❑ Peripheral Interventions ❑ Renal Stenting ❑ Femoral ❑ Iliac	❑ Jugular ❑ Renal ❑ Temporal

3. Qualifications

(Please attach any relevant documentation)

Degree/Fellowship	Conferring Body	Year

4. Details of Membership of Professional Associations

5. Current Appointments

Facility	Appointments

6. Past Appointments

Facility	Appointments

7. References

Please provide details below for three peer references who can attest that your recent practice is consistent with the criteria contained within the St George Private Hospital Facility Rules. We prefer (where possible) that these references are independent. However, where there is a relationship which can lead to a bias, such as a referee and the applicant are in business together as a partnership or are employer/employee, then this relationship must be disclosed by you to the hospital. The referees provided should be familiar with your current professional capabilities.

Please note that your referees will be contacted and asked to provide a reference. The reference should be in writing.

Name		**Address**	
Phone:		Fax:	
Email:			

Name		**Address**	
Phone:		Fax:	
Email:			

Name		**Address**	
Phone:		Fax:	
Email:			

8. Registration

Please supply details of your current registration with the Medical Board.

Registration Number: ……………………………………………………………………………………..

Expiry Date: ………………………………………………………………………………………….……...

Conditions:…………………………………………………………………………………………………

<u>Please attach a copy of the current Registration Certificate</u>

NB: IT IS THE RESPONSIBILITY OF THE PRACTITIONER TO PROVIDE CURRENT COPIES OF MEDICAL REGISTRATION TO THE FACILITY UPON RENEWAL. FAILURE TO DO SO COULD HAVE AN ADVERSE IMPACT ON THE PRACTITIONERS APPOINTMENT.

9. Insurance

It is the responsibility of the applicant, that they hold an appropriate level of insurance and provide a copy of the policy for review.

Please note that by submitting this application you consent to a representative from Ramsay Health Care contacting your medical defense organisation / insurer to verify that you maintain appropriate medical indemnity coverage for the privileges sought.

Do you have current Medical Indemnity Insurance at the appropriate level? Yes ☐ No ☐

Please provide details:

Insurer:……………………………Policy No:……………………………………Expiry date:…….……..

Category of Cover held:………………………………..……………………………….……………..

<u>Please attach a copy of your Medical Insurance Policy / Schedule not just your membership card. It is important that the Hospital ascertains the level of your insurance to ensure this sufficiently covers the requested scope of practice.</u>

NB: IT IS THE RESPONSIBILITY OF THE PRACTITIONER TO PROVIDE CURRENT COPIES OF MEDICAL INDEMNITY TO THE FACILITY UPON RENEWAL. FAILURE TO DO SO COULD HAVE AN ADVERSE IMPACT ON THE PRACTITIONERS APPOINTMENT.

If you hold employer indemnification you <u>must</u> ensure you have a portion of cover for private practice.

10. Professional Development

Please provide details (e.g. courses attended relevant to your appointment) of your compliance with the Continuing Education/Professional Development/Recertification or Maintenance of Standards Program of your College.

……….……………………………………………………………………………………………………

………

………

11. Fluoroscopic X-Ray Equipment

Please Note:

All Practitioners operating fluoroscopic x-ray equipment are required to hold a Radiation License with the Environmental Protection Agency (EPA) and have undertaken an approved radiation safety course. Therefore, if applicable to you, please state the following **and provide a copy of your current license with your application.**

☐ N/A ☐ License held, details as follows:

License No:……………………………………..Expires:……………………………………………

Course Date:………………………………………Location:……………………………………………..

12. Laser Equipment

Please Note:

All Practitioners operating laser equipment are required to hold accreditation to do so, having successfully completed an appropriate training course. Therefore, if applicable to you, please state the following **and provide a copy of your accreditation certificate with your application.**

☐ N/A ☐ Training completed, details as follows:

Certificate No:……………………………………..Expires:……………………………………………

Course Date:………………………………………Location:……………………………………………..

13. Disclosure

a) Have you ever had any restrictions placed on your Medical Registration? Yes ☐ No ☐

If you answered yes to the above, please provide details (including details of the restriction and what period during which the restrictions apply/applied):

………..

………..

b) Have you previously been refused clinical privileges at another health care facility?

Yes ☐ No ☐

If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note, a senior executive of the hospital may contact the facility.

………..

………..

c) Have your clinical privileges ever been withdrawn, suspended or not renewed on the basis of clinical competency at another hospital? Yes ☐ No ☐

If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note, a senior executive of the hospital may contact the facility.

………..

………..

d) Have there ever been any serious adverse findings made against you which would be relevant to your appointment (for example: breach of insurance / medical laws, professional misconduct, sexual assaults or assault) by the, Health Insurance Commission, a Medical Board, a Health Care Complaints Commission/Body, a Coroner, a Court or any other professional disciplinary or similar body? Yes ☐ No ☐

If you answered yes to the above, please provide details:

………..

………...

13. Disclosure (continued)

e) Criminal Record Check – Have you been convicted of or pleaded guilty to a criminal offence including a serious sex or violence offence or an offence involving dishonesty or drugs (other than a spent conviction)? Yes ☐ No ☐

If you answered yes to the above, please provide details:

………..

NSW Applicants Only- Working with Children

A Working with Children Check is required of applicants in NSW who will be undertaking direct and unsupervised contact with children as a primary function in the course of their work.

Are you likely to be undertaking child related work meeting the definition above? Yes ☐ No ☐

If you answered yes to the above question, do you consent to make a prohibited Employment Declaration and a Background Check, as prescribed by the relevant law? Yes ☐ No ☐

14. Nomination Alternative in event of A Clinical Emergency

NB: This should not be a relative but an accredited colleague in the same specialty at the same facility.

In the event that I am unable to be contacted for a **clinical** emergency, the person nominated below is an appropriately qualified Accredited Practitioner at **St George Private Hospital,** who has agreed to deputise for me. *(Please note this is not required for Surgical Assistants)*:

Name: …………………………………………………………………..……………………………………

Contact Phone Numbers: …………………………………….……………………………………………

15. Representation and warranty

The information provided by me to Ramsay Health Care in this application and in connection with this application is accurate and complete and is not misleading or deceiving or likely to mislead or deceive.

I understand that if I have provided misleading or deceptive information or information which is likely to mislead or deceive that the Board of Ramsay Health Care Pty Limited may (in its absolute discretion) consider that I do not have "current fitness" under the Hospital Facility Rules.

I agree that I will notify the CEO of **St George Private Hospital** of any material changes to the information provided by me in connection with this application as soon as possible after the change.

I understand that my Appointment as a Visiting Medical Officer if granted, will be reviewed in **one** year or earlier if considered necessary.

I acknowledge that I have been provided with, and, read a copy of the Hospital Facility Rules. If appointed, I agree to abide by the policies and Facility Rules of **St George Private Hospital.**

Signature: ________________________________ **Date:** __________

Witness Name: ____________________________ **Date:** __________

Signature: ________________________________

Return to: **Chief Executive Officer**
St George Private Hospital
1 South Street
KOGARAH NSW 2217

Phone: **02 9598 5421**
Fax: **02 9598 5433**

Checklist:

- ❑ Completed Application
- ❑ Current Resume
- ❑ Copy of Qualifications
- ❑ Copy of College Fellowship
- ❑ Copy of Letter of Recognition from Medicare Australia for Specialist status
- ❑ Current Medical Board Registration
- ❑ Current Medical Indemnity
- ❑ EPA Radiation Licence (if applicable)
- ❑ Current CME Certificate

NOTE: If you are applying for privileges for interventional procedures, laser procedures, advanced laparoscopy or Endoscopy, you are required to provide evidence of your training and experience in these areas over the past 12 months minimum.

RAMSAY HEALTH CARE

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APPENDIX A

Competencies

Cardiology / Endovascular

CLINICAL PRACTICE SOUGHT AS THE FOLLOWING SPECIALIST(S) IN THE CARDIOVASCULAR UNIT:

- ❑ Cardiologist
- ❑ Interventional Cardiologist
- ❑ Procedural Cardiologist
- ❑ Electrophysiologist

DETAIL THE AREAS OF CLINICAL PRACTICE REQUESTED:

- ❑ Cardiology
  - ❑ Diagnostic Procedures
  - ❑ Interventional Procedures
  - ❑ EPS/Ablation Procedures
  - ❑ Implantable:
    - ❑ Pacemaker
    - ❑ Biventricular Pacemaker
    - ❑ AICD
  - ❑ Trans-oesophageal Echocardiography (TOE) – Adult Only
- ❑ Endovascular Procedures
  - ❑ Diagnostic Procedures
  - ❑ Peripheral Interventions
  - ❑ Carotid Interventions
  - ❑ AAA Stent Grafts
  - ❑ Embolisation Procedures
  - ❑ Renal Stenting

COMPETENCY GUIDELINES (AS PER CSANZ GUIDELINES):

	During Training or within the last 5 years of Clinical practice (Did you meet or exceed these amounts? If not what quantity?)	**Current Practice – Across all institutions you visit** (Do you meet or exceed these amounts? If not what quantity?)
Cardiology		
Diagnostic Procedures	❑ Participate in 400 coronary Angiograms ❑ Perform 150 cases as supervised operator ❑ Perform 150 cases as primary operator	❑ 100 cases / year
Interventional Procedures	❑ Participate in 400 cases (100 complex) ❑ Perform 200 cases as primary operator	❑ 75 cases / year
Electrophysiology Studies	❑ Participate in 150 diagnostic cases ❑ Participate in 100 ablation cases ❑ Perform 50 cases as primary operator ❑ Perform 10 trans-septal catheterisations	❑ 50 cases / year (30 as ablations)
Implantable Electronic Devices (pacemakers and ICD's – single, dual & Bi V, active & passive fixation)	❑ Perform 75 implants ❑ Perform 20 revisions ❑ Perform 15 Bi-Ventricular implants	❑ 12 PM & 10 ICD implants / year ❑ 5 revisions / year ❑ Follow 50 PM & 20 ICD patients / year
Cardiac Interventions (valvuloplasty, PFO/ASD closures etc)		❑ 5 cases / year
Endovascular		
Perform Angiography	❑ Perform 100 cases (50 as primary operator)	❑ 20 cases / year
Peripheral Interventions	❑ Perform 50 cases (25 as primary operator)	❑ 20 cases / year
Carotid interventions	❑ Perform 100 Peripheral angiograms (not only carotids) ❑ Perform 15 cases (10 as primary operator	❑ 10 cases / year
AAA Stent Grafts	❑ Perform 10 cases (5 as primary operator)	❑ 5 cases / year

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APPENDIX B

Competencies

Interventional Radiology Service

It has been determined by I.R.S.A. that there are two tiers of interventional radiology.

TIER A (Any individual with RANZCR or equivalent qualifications may perform)
Basic diagnostic angiography and interventional techniques:

- ❑ Angiography
- ❑ Nephrostomy
- ❑ Abscess drainage
- ❑ Biopsy.

TIER B (Evidence is required – plus completion of Appendix B)

Procedures

- ❑ All neuro-interventional procedures intracranial and extracranial
- ❑ All vascular interventional procedures other than basic diagnostic angiography, i.e. stents, angioplasty, thrombolysis, thrombectomy, atherectomy, embolisation, retrieval of foreign bodies and laser and mechanical angioplasty
- ❑ Venous and arterio-venous graft interventions other than basic diagnostic venography or fistulography, i.e. thrombolysis, angioplasty, stents, atherectomy, pulmonary embolectomy/thrombolysis and caval filter insertion
- ❑ Biliary intervention including T.I.P.S.
- ❑ Thoracic intervention, i.e. embolisation of AVMs, bronchial stents, occlusion of broncho-pleural fistulae and bronchial artery embolisation
- ❑ Gastro-intestinal intervention, i.e. oesophageal and duodenal stents, percutaneous gastrostomy, gastrointestinal vascular procedures other than diagnostic angiography, i.e. embolisation, chemo-embolisation and transplant intervention.
- ❑ Urological intervention, i.e. renal artery embolisation, angioplasty or stenting, percutaneous nephrolithotomy
- ❑ Gynaecological - fallopian tube recanalisation, embolisation of fibroids, temporary aortic occlusion
- ❑ Orthopaedic - percutaneous vertebroplasty, percutaneous discectomy

Minimum Training Requirements/Evidence:

- ❑ Performance of 300 peripheral angiograms under accredited supervision
- ❑ Performance of 50 peripheral/renal angioplasties with 25 as primary operator, with at least 10 using an antegrade femoral approach
- ❑ Performance of 30 vascular stents (15 as primary operator)
- ❑ Performance of 20 cases of peripheral vascular thrombolysis (10 as primary operator)
- ❑ Performance of 10 cases of peripheral catheter guided thrombus aspiration (5 as primary operator)
- ❑ Ultrasound guided vessel puncture (20 cases as primary operator)
- ❑ Completion of an approved course in radiation biology and protection equivalent to that provided to F.R.A.N.Z.C.R. candidates

These procedures should have been performed in an I.R.S.A./ R.A.N.Z.C.R accredited site open to peer review and audit with indications, primary success and complications documented. Combined procedures are to be counted as one procedure with the exception of ultrasound guided punctures. (Angiogram + angioplasty + stent + aspiration + thrombolysis = one procedure)