

|  |
| --- |
| EXPRESSION OF INTEREST 2022**FORM** |

This form is to be used by medical practitioners expressing interest in appointment as an Independent Medical Adviser (IMA) in accordance with the *Return to Work Act 2014*.

More information and an electronic version of this form are available at: <http://treasury.sa.gov.au/independent-medical-advisers>.

**EXPRESSION OF INTEREST**

|  |  |
| --- | --- |
| **EOI opens** | Friday, 28 January 2022 |
| **EOI closes** | 5:00pm, Friday, 18 February 2022 |

**HOW TO SUBMIT**

|  |  |
| --- | --- |
| **Address to** | IMA Selection Committee |
| **Email** | DTFIMA@sa.gov.au |

**CONTACT**

|  |  |
| --- | --- |
| **Enquiries** | Fiona Macdonald |
| **Email** | DTFIMA@sa.gov.au |
| **Telephone** | (08) 8463 4443 |

|  |  |
| --- | --- |
| Text  Description automatically generated | Logo  Description automatically generated |

# PERSONAL DETAILS

|  |  |
| --- | --- |
| Title (eg Dr, Prof) |  |
| First name(s) |  |
| Last name |  |
| Phone Preferred |  |
| Phone Alternative |  |
| Email |  |
| Practice address |  |

# MEDICAL REGISTRATION & SPECIALISATIONS

|  |  |
| --- | --- |
|  | Please attach a copy of your **current certificates of registration**. |
| Medical Board of Australia (AHPRA) registration number |  |
| AHPRA specialist membership |  |
| Are there any restrictions placed on your registration? | [ ]  No [ ]  Yes  |

If ‘Yes’, please specify the restriction. Attach any relevant documents if required.

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Are you accredited as a Return to Work Impairment Assessor: | [ ]  No [ ]  Yes [ ]  Pending  |

Please check the box(es) corresponding with the **specialisation(s)** this expression of interest relates to:

|  |  |  |
| --- | --- | --- |
| [ ]  Cardiologist | [ ]  ENT Surgeon | [ ]  General Medicine Specialist |
| [ ]  Infectious Diseases Physician | [ ]  Obstetrician & Gynaecologist | [ ]  Orthopaedic Surgeon |
| [ ]  Psychiatrist | [ ]  Rheumatologist | [ ]  General Surgeon |
| [ ]  Dermatologist | [ ]  Gastroenterologist | [ ]  Pain Medicine Specialist |
| [ ]  Neurologist | [ ]  Occupational Physician | [ ]  GP |
| [ ]  Rehabilitation & Pain Physician | [ ]  Thoracic Physician | [ ]  Plastic & Reconstructive Surgeon |
| [ ]  Endocrinologist | [ ]  Gen & Resp Med Physician | [ ]  Ophthalmologist |
| [ ]  Neurosurgeon | [ ]  Other, please specify:  |  |

Please check the box(es) corresponding with the **accreditation** this expression of interest relates to:

|  |  |  |
| --- | --- | --- |
| [ ]  Central and Peripheral Nervous | [ ]  Cardiovascular | [ ]  Respiratory |
| [ ]  Digestive | [ ]  Urinary and Reproductive | [ ]  Skin |
| [ ]  Haematopoietic | [ ]  Endocrine | [ ]  ENT and Related Structures |
| [ ]  Visual | [ ]  Psychiatric Disorders | [ ]  ENT Hearing |
| [ ]  Upper Extremity | [ ]  Lower Extremity | [ ]  Spine |
| [ ]  Other, please specify: |  |

# MEDICAL QUALIFICATIONS

|  |  |
| --- | --- |
|  | **You must have at least five years post-fellowship experience or 12 years post- graduation experience if no fellowship is held.** |

**Primary qualification** (degree)

|  |  |  |  |
| --- | --- | --- | --- |
| **QUALIFICATION** (Please write in full) | **AWARDING UNIVERSITY / COLLEGE / INSTITUTION** | **COUNTRY** | **YEAR** |
|  |  |  |  |

**Postgraduate qualification** (e.g. diploma, certificates, degrees, memberships, fellowships)

|  |  |  |  |
| --- | --- | --- | --- |
| **QUALIFICATION** (Please write in full) | **AWARDING UNIVERSITY / COLLEGE / INSTITUTION** | **COUNTRY** | **YEAR** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# INSURANCE

|  |  |
| --- | --- |
|  | Please attach a copy of your **certificates of currency**. |

|  |  |
| --- | --- |
| Are you covered by medical indemnity insurance? | [ ]  Yes  |
| Are you covered by public liability insurance? | [ ]  Yes  |

# CONTINUING PROFESSIONAL DEVELOPMENT

|  |  |
| --- | --- |
|  | Please, attach a copy of your latest **certificate of maintenance** or **evidence of recent post-graduate development**. |

|  |  |
| --- | --- |
| Do you have up-to-date certification of maintenance of professional standards or continuing professional development relevant to your specialty? | [ ]  Yes  |

# CLINICAL PRACTICE

|  |  |
| --- | --- |
|  | \*“**Active clinical practice**” defined as the ‘clinical management (consulting and treatment) of patients’ injuries and illnesses’. (Must be 8 hours minimum) and excludes medical legal work.The Committee may, in limited circumstances, such as where limited specialists are available make exception to the active clinical practice requirement. |

|  |  |
| --- | --- |
| How many hours **per month**, on average, do you spend in: | **AVERAGE HOURS PER MONTH** |
| 1. Medical practice (must be 40 hours minimum)
 |  |
| 1. Active clinical practice (GP)?
 |  |
| 1. Active clinical practice (Specialist)?
 |  |
| 1. Medico-legal assessment and reporting
 |  |
| 1. Other, please specify:
 |  |  |

|  |  |
| --- | --- |
| If retired from medical and active clinical practice, how many years since retirement? (Preference will be given to people with active clinical practice) |  |

# PROFESSIONAL REFEREES

|  |  |  |
| --- | --- | --- |
| **Referee 1** | Name |  |
|  | Position |  |
|  | Phone |  |
|  | Email |  |
|  |  |  |
| **Referee 2** | Name |  |
|  | Position |  |
|  | Phone |  |
|  | Email |  |

# CONFIDENTIAL PROFESSIONAL INFORMATION

Please complete all of the following questions. If **‘yes’**, please gives dates and particulars.

|  |  |  |
| --- | --- | --- |
| Have you ever been investigated or are currently under investigation by any medical board in any State/ Territory of Australia or overseas? | [ ]  No[ ]  Yes  |  |
| Are there any restrictions placed on your registration with the Medical Board of Australia? | [ ]  No[ ]  Yes  |  |
| Have any claims, investigations or lawsuits for malpractice been made against you in the past five years? | [ ]  No[ ]  Yes  |  |
| Has a criminal conviction of a serious nature including sexual assault been made against you in the past five years?Note: Appointment is dependent upon a National Police Clearance that the Selection Committee finds satisfactory. | [ ]  No[ ]  Yes  |  |
| Has there ever been any civil or criminal action against you, where there was a finding of liability or guilt with respect to your clinical practice in the last five years? | [ ]  No[ ]  Yes  |  |
| Do you have any physical or mental condition or substance abuse problem, including a Section 57 Prohibition Order under the Controlled Substances Act that could affect your ability to competently undertake the duties required of an Independent Medical Adviser? | [ ]  No[ ]  Yes  |  |

|  |
| --- |
| PLEASE PRINT AND COMPLETE THE REST OF THE FORM IN HARDCOPY |

# AUTHORISATION

I hereby authorise any member of the Independent Medical Adviser Selection Committee to make an enquiry to the Medical Board of Australia for any information that may be material to the questions in Part 8 of this form.

|  |  |
| --- | --- |
| Signature |  |
| Date |  / / 2022 |

# DECLARATION

|  |  |
| --- | --- |
| I  | (Name) |
| of | (Address) |

declare that I am the person named in this application and that, to the best of my knowledge and belief, the statements herein contained are true and correct.

I understand that:

* Any incorrect statement in my expression of interest including (but not restricted to) my qualifications, experience, ability, physical or mental health or personal integrity, may result in refusal of my expression of interest.
* If appointed as an Independent Medical Adviser (IMA), I must comply with the terms and conditions and fees of my appointment.

I hereby authorise the IMA Selection Committee to seek information relating to my qualifications, professional standing and past experience as relevant to my application. Also, if I am appointed as an IMA I give permission for SAET to provide my name and contact details to Return to Work SA to contact me for scheduling permanent impairment assessor training.

|  |  |
| --- | --- |
| Signature |  |
| Date |  / / 2022 |

# EXPRESSION OF INTEREST CHECKLIST

Please check that your EOI is complete, including supporting evidence.

|  |  |
| --- | --- |
|  | **INCLUDED IN EOI** |
| 1. EOI form
 | [ ]  Yes |
| 1. National Police Check - evidence of NPC less than 12 months old or authorised NPC application form and copies of 100 points of ID
 | [ ]  Yes |
| 1. Curriculum Vitae
 | [ ]  Yes |
| 1. Copy of current certificate of registration from the Medical Board of Australia
 | [ ]  Yes |
| 1. Copy of current certificate of registration as a specialist from AHPRA
 | [ ]  Yes |
| 1. Copy of Certificate of currency - medical indemnity insurance
 | [ ]  Yes |
| 1. Copy of Certificate of currency - public liability insurance
 | [ ]  Yes |
| 1. Copy of Certificate of maintenance - Continuing Professional Development (CPD)
 | [ ]  Yes |
| 1. Any other supporting evidence
 | [ ]  Yes |

# SUBMITTING YOUR EOI

**EXPRESSION OF INTEREST**

|  |  |
| --- | --- |
| **EOI opens** | Friday, 28 January 2022 |
| **EOI closes** | 5:00pm, Friday, 18 February 2022 |

**HOW TO SUBMIT**

|  |  |
| --- | --- |
| **Address to** | IMA Selection Committee |
| **Email** | DTFIMA@sa.gov.au |

**CONTACT**

|  |  |
| --- | --- |
| **Enquiries** | Fiona Macdonald |
| **Email** | DTFIMA@sa.gov.au |
| **Telephone** | (08) 8463 4443 |

Your privacy is respected. Information supplied will be stored securely and not disclosed to any other person other than as required for the purposes of:

* assessing the suitability for appointment as an Independent Medical Adviser
* providing contact details for permanent impairment assessor training to Return to Work SA if consent is given.