BAYVIEW HOSPITAL

Quality Healthcare

ADMITTING PRIVILEGES APPLICATION

Bayview Hospital
St. Paul's Avenue, Bayville,
St. Michael, BB14021
Barbados

(246) 436-5446

info@ bayviewhospital.com.bb

www.bayviewhospital.com.bb

DEAR MADAM,

I, _____ HEREBY APPLY FOR ADMITTING PRIVILEGES TO BAYVIEW HOSPITAL AND FULL USE OF THE FACILITY. MY AREA OF PRACTICE IS _____

AND I HAVE THE FOLLOWING QUALIFICATIONS.* (*PLEASE SUBMIT COPY OF QUALIFICATIONS).

QUALIFICATION	EXAMINING BODY	YEAR QUALIFIED

I UNDERSTAND THAT I WILL ONLY BE ALLOWED TO ADMIT PATIENTS WITHIN MY SPHERE OF PRACTICE AND ANY DEPARTURE FROM THIS MAY RESULT IN WITHDRAWAL OF MY ADMITTING PRIVILEGES.

I HEREBY AGREE TO WORK WITHIN THE RULES OF THE HOSPITAL AND WILL STRIVE TO MAINTAIN ITS GOOD REPUTATION.

I UNDERSTAND THAT IF I AM UNAVAILABLE TO REVIEW MY PATIENT IN MY ABSENCE THE PATIENT WILL BE MANAGED BY ANOTHER PHYSICIAN IN MY SPECIALTY AREA

YOURS SINCERELY,

_____

DATE: _____

NOTE: APPLICATION MUST BE ACCOMPANIED BY:-

- **COPY OF CURRENT BARBADOS REGISTRATION CERTIFICATE**
- **UP TO DATE CV**
- **COPY OF QUALIFICATION(S)**
- **NAMES OF TWO (2) REFEREES**
- **COMPLETED QUESTIONNAIRE (ATTACHED)**
- **IF A NON-NATIONAL, EVIDENCE OF IMMIGRATION STATUS (WORK PERMIT / CARICOM SKILLED NATIONAL CERTIFICATE)**

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NAME: _____

1. NAMES OF CURRENT / PREVIOUS HOSPITALS / HEALTH INSTITUTIONS WHERE YOU HAVE WORKED.

INSTITUTION	DATES OF STAFF MEMBERSHIP
	FROM TO
	FROM TO
	FROM TO
	FROM TO
	FROM TO
	FROM TO

2. HAVE YOUR CLINICAL PRIVILEGES AT ANY OF THE ABOVE INSTITUTIONS EVER BEEN DENIED, REVOKED, RESTRICTED OR GRANTED WITH LIMITATIONS? ☐ YES ☐ NO

3. HAS YOUR LICENCE TO PRACTISE MEDICINE IN ANY JURISDICTION EVER BEEN LIMITED, SUSPENDED, REVOKED, DENIED OR SUBJECTED TO PROBATIONARY CONDITIONS? ☐ YES ☐ NO

4. HAVE YOU EVER BEEN INVOLVED IN ANY MALPRACTICE LITIGATION OR CLAIM? ☐ YES ☐ NO

5. HAVE YOU EVER BEEN DISCIPLINED OR COUNSELLED FOR ANY BEHAVIOURAL, HEALTH, SUBSTANCE ABUSE OR HEALTH CARE PROBLEMS? ☐ YES ☐ NO

6. HAVE YOU EVER BEEN CONVICTED OF A CRIME? ☐ YES ☐ NO

IF YOU HAVE ANSWERED 'YES' TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET.

SIGNED: _____

DATE: _____

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ADDITIONAL INFORMATION

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AUTHORISATION & IMMUNITY STATEMENT

I _____ HEREBY AUTHORISE ALL INDIVIDUALS, INSTITUTIONS AND ENTITIES (PAST, PRESENT AND FUTURE), INCLUDING ALL PROFESSIONAL LICENSING BODIES AND LIABILITY INSURERS WITH WHICH I HAVE HAD OR CURRENTLY HAVE PROFESSIONAL LIABILITY INSURANCE, (INCLUDING PAST AND PRESENT CLAIMS HISTORY), WHO HAVE KNOWLEDGE CONCERNING INFORMATION REQUESTED IN THIS APPLICATION, TO CONSULT WITH AND RELEASE RELEVANT RECORDS TO BAYVIEW HOSPITAL (2014) LTD, BARBADOS.

THESE RECORDS MAY BE RELEASED IN THE FORM OF THEIR ORIGINAL COPY, PHOTOCOPY OR FAX, ANY OF WHICH SERVE AS EFFECTIVE DOCUMENTATION.

I RELEASE FROM LIABILITY ALL THOSE FURNISHING INFORMATION, FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN CONNECTION WITH THE GATHERING AND EXCHANGE OF INFORMATION AS CONSENTED ABOVE.

A PHOTOCOPY OR FAX OF THIS WAIVER SHALL BE AS EFFECTIVE AS THE ORIGINAL WHEN SO PRESENTED.

I CERTIFY THAT ANSWERS GIVEN IN THE ATTACHED APPLICATION FORM ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORISE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THE APPLICATION. I FULLY UNDERSTAND AND AGREE THAT AS A CONDITION TO MAKING THIS APPLICATION, ANY MISREPRESENTATIONS OR MISSTATEMENTS, OR OMISSIONS, WHETHER INTENTIONAL OR NOT, SHALL CONSTITUTE CAUSE FOR AUTOMATIC AND IMMEDIATE REJECTION OF THIS APPLICATION. IN THE EVENT THAT ADMITTING PRIVILEGES HAVE BEEN GRANTED PRIOR TO THE DISCOVERY OF SUCH MISREPRESENTATIONS, MISSTATEMENTS OR OMISSIONS, SUCH DISCOVERY MAY RESULT IN IMMEDIATE WITHDRAWAL OF SUCH PRIVILEGES.

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____