

Section 1: Personal Details

Title	Family Name/Surname
<input type="text"/>	<input type="text"/>

Given Name/s

Previous/Other names known as

Daytime Contact Number	Mobile Number
<input type="text"/>	<input type="text"/>

Email

Street Address (must NOT be a PO Box)  
Unit number/Street number/Property number (include Lot or DP number if applicable)

Street Name

Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>

Postal Address (if different to street address)

☐ Same as street address

Unit number/Street number/Property number (include Lot or DP number if applicable)

Street Name

Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>

Vaccination Status

Provide information relating to your current COVID-19 vaccination status.

☐ Fully Vaccinated (2/3 doses) ☐ Partially Vaccinated (1 dose) date of 2<sup>nd</sup> dose \_\_/\_\_/\_\_\_\_

I intend to undertake booster program as required ☐ Yes ☐ No.

☐ Not Vaccinated. If not, do you have a medical exemption? ☐ Yes ☐ No

☐ I choose not to indicate vaccination status.

**NB Your vaccination status may impact the allocation of matters to you.**

## Section 2: Division and Assessment types

### 2.1 Select Division/s and all applicable assessment types

DIVISION/S: ☐ Police Officer Support Scheme ☐ Motor accidents ☐ Workers Compensation

DISPUTE TYPES (select by Division and type)

Motor Accidents Division: ☐ Permanent impairment ☐ Threshold Injury ☐ Treatment

Workers Compensation: ☐ Permanent impairment ☐ General Medical Dispute

## Section 3: Professional Details

### 3.1 List your professional qualifications.

### 3.2 List any sub-specialties and/or special interest areas.

### 3.3 List details of your permanent impairment training and attach a copy of your training certificate(s) of AMA 4 and/or AMA 5.

### 3.4 Provide your AHPRA professional registration number.

### 3.5 Provide evidence of your continuing professional development through participation in education, training, conferences or research, etc. Where relevant, attach a copy of your record of MOPS activities for the last two years.

### 3.6 Provide the name of the college or faculty you are a member, your membership number and your level of membership. Attach evidence of your college or faculty membership.

### 3.7 If you are applying to assess treatment disputes, describe how you keep up to date with evidence-based best practice in your area of specialty and any other specialty areas.

## Section 4: Assessment Venues

4.1 Are you willing to travel to the following places to undertake assessments?

- a. Rural or Regional NSW ☐ Yes ☐ No
- b. Interstate ☐ Yes ☐ No
- c. Detention facilities ☐ Yes ☐ No
- d. Correctional facilities ☐ Yes ☐ No
- e. A Claimant's home ☐ Yes ☐ No

4.2 Do you regularly travel to more than one venue for consultations or assessments?

☐ Yes ☐ No

If yes, list the additional venues where you would be able to conduct assessments (include the name of the venue and the suburb/town).

4.3 Are you able to undertake assessments outside of usual business hours?

☐ Yes ☐ No

4.4 Are you willing to conduct examinations from the Commission's Medical Suite at 1 Oxford St Darlinghurst? There is no cost for use of these rooms.

☐ Yes ☐ No

If yes, please provide details of preferred days, number of assessments per session and session duration

## Section 5: Working with Children

5.1 Do you have Working with Children Check (WWCC) clearance?

☐ Yes ☐ No

If yes, please provide your WWCC number

5.2 Are you willing to assess children?

☐ Yes ☐ No

If yes, please indicate from what age you are available to assess, for example - all children or aged 10 and over etc

5.3 Do you have WWCC clearance (or its equivalent) in any other state?

☐ Yes ☐ No

If yes, please provide details of those States and approval numbers

5.4 Provide details of your clinical experience in treating and assessing children.

## Section 6: Conflict of Interest Disclosure

6.1 Will your appointment as a Medical Assessor give rise to any relationships, direct or indirect, or potential conflicts of interest, which require disclosure? This includes work conducted for insurers, legal firms, other government agencies or private employers.

☐ Yes ☐ No

If yes, please give details.

6.2 Please provide an estimate on your current workload: (for allocation of treatment and general medical dispute allocations)

- a. Percentage of clinical treatment/teaching if any
- b. Percentage of medico-legal work for insurers if any
- c. Percentage of medico-legal work for lawyers if any


## Section 7: Declaration, Identity and Background Check

Consent to background and criminal check.

Please provide all relevant information about your identity and any criminal convictions or proceedings.

1. Have you ever been convicted of a criminal offence/s or had findings of guilt recorded against you in Australia or anywhere else (including any conviction which is now removed from official records)?

☐ Yes ☐ No

If yes, please specify the criminal offence or findings of guilt recorded against you, the date of the conviction or the finding of guilt and the relevant jurisdiction for the conviction or finding (i.e. nation and/or state).

*In considering your answers, please note, that a conviction which is 'spent' within the meaning of the spent convictions scheme as in force in each state and territory, may be disclosed to or considered by the Commission. Whether a conviction is spent will depend on the spent conviction's legislation or policy as in force in the state where the conviction is recorded. Should you have queries about spent convictions, please refer to the state or territory police force in which the conviction is recorded.*

2. Have you ever been known by a name/s other than the name under which you are making this application? ☐ Yes ☐ No

If yes, please provide the following on each and every name, by which you have ever been known.

- All forms of names
- Timeframes for your use of each name
- Country/s where you used the names
- Attach proof of your name change

3. Have you ever been charged with any offence that is currently awaiting legal action?

☐ Yes ☐ No

4. Have you ever been the subject of a domestic or family violence order, or any other order, of a tribunal or court or other similar authority, for the personal protection of another person?

☐ Yes ☐ No

5. Please provide any additional information the Commission should consider or be made aware of regarding your background.

## Section 8: Referees

Please provide three (3) Referees the Commission may contacted and who can comment on your experience in a recent capacity.

	Referee Name	Position	Contact Number
Referee 1			
Referee 2			
Referee 3			

### Consent

- ☐ I give consent to a comprehensive probity and background check being conducted about me and each and every name, by which I have ever been known.
- ☐ I give consent to the Commission conducting or arranging for a nationwide police check, in relation to me (that is a police check conducted in each state and territory of Australia).
- ☐ I give consent to the Commission conducting or arranging for an international police check, in relation to me (that is a police check conducted in jurisdictions outside Australia).
- ☐ I give consent to the Commission conducting a comprehensive probity check including, but not limited to, checks of identity, qualifications, registration, criminal history and referees.
- ☐ I confirm that, to the best of my knowledge, the information I have provided is true and correct. I understand that any misleading statements or omissions may make me ineligible for appointment.

### Declaration

- ☐ I have read and understood the Medical Assessor Applicant Information.
- ☐ I have read and understood the Medical Assessor Code of Conduct and Terms of Appointment.
- ☐ I confirm that I have in place the relevant Professional Indemnity, Public Liability and Workers Compensation Insurance and can provide copies on request.
- ☐ I understand that if I am not completely honest when completing this application form, I may breach section 307B of the Crimes Act 1900 NSW; and this will constitute a valid reason for the Commission to terminate any appointment made based on the application form.
- ☐ I understand that the Commission is committed to protecting my personal information in accordance with privacy legislation. The personal information (that is, information that identifies me) and sensitive information (such as criminal history) collected in this application form:
- Is required by the Commission to see if I am eligible for appointment and to be included in a public list of Medical Assessors;
  - Will be used to manage my appointment (if successful in your application); and
  - May be used for communications purposes.

Full Name

Applicant's Signature

Date

## Application Document Checklist

Attach the following when submitting your application:

- ☐ A copy of your curriculum vitae.
- ☐ A copy of your permanent impairment training certificate(s).
- ☐ A copy of your record of Maintenance of Professional Standards (MOPS) activities for the last two years (where relevant).
- ☐ A copy of your college or faculty membership.
- ☐ Sample of 2 de-identified medical reports or certificates.

## Further enquiries

Any questions about becoming a Medical Assessor can be directed to [medicalassessors@pi.nsw.gov.au](mailto:medicalassessors@pi.nsw.gov.au)

Email your application and supporting documents to [medicalassessors@pi.nsw.gov.au](mailto:medicalassessors@pi.nsw.gov.au)

We strongly recommend that you keep a copy of this completed form for your records.