**South Eastern Sydney Division of General Practice Ltd**
**Level 2, 6-8 Crewe Place, Rosebery, 2018 – Tel 02 9663 5958 – Fax 02 9663 5817**
**Web www.sesdgp.com.au – Email admin@sesdgp.com.au – ABN 9109 898 2202**

**ATAPS Application Form** - To become an eligible service provider under the South Eastern Sydney Division of General Practice Limited Access to Allied Psychological Services Project (ATAPS) 2010/11

**Contact Details:**

| Name | | |
|---|---|---|
| Type of professional | ❑ Clinical Psychologist<br>❑ Psychologist<br>❑ Social Worker<br>❑ Aboriginal and Torres Strait Islander Health Worker<br>❑ Mental Health Nurse<br>❑ Occupational Therapist | |
| Name of practice/s | | |
| Address of practice/s (located in the SESDGP list of postcodes) | 1. | 2. |
| Is this practice co-located with a General Practice? | Yes ☐ No ☐.If yes, name of General Practice? ................................................ | Yes ☐ No ☐ If yes, name of General Practice? ................................................................... |
| Postal Address | | |
| Phone | | |
| Fax | | |
| Mobile | | |
| Email address | | |
| ABN | | Medicare Provider No: |
| Initial appointment waiting period and days and times of availability | | I agree that I will not charge the referred patient any co-payment for services provided by me through this project: *(please circle)*<br>Yes No |
| Other relevant details (Such as accreditation for alternative referral pathways, disabled access, public transport access) | 1. Are you registered with Medicare Australia (HIC) for EPC item numbers? ................<br>2. Are you an accredited provider through Victims of Crime Bureau? ..........................<br>3. Are you an accredited provider through Motor Accidents Authority? .........................<br>4. Are you an accredited provider through the Family Court of Australia? ......................<br>5. Are you an accredited provider through Vietnam Vets Counselling Service? .............<br>6. Are you accredited though any other specialised pathways? If so please describe? ..........................................................................................................................<br>7. Do you have disabled access? ....................................................................................<br>8. Are you close to public transport? If so please describe station stop or bus route? .......................................................................................................................... | |

**Essential Criteria – Registration, insurance and professional association membership:**

| Requirement | Criteria | Evidence of meeting criteria |
|---|---|---|
| Registration | Current & full registration with the Psychologists Registration Board of NSW | Registration no: …………………….<br>*(Please attach photocopy)* |
| Insurance | Public Liability & Professional Indemnity Insurance of $5 million each or $10 million combined policy | *(Please attach policy or certificate of currency)* |
| Professional body | Current full member of a professional body with ethical and professional guidelines and accountability and disciplinary procedures | *(Please attach photocopy of current membership)* |

**Essential Criteria – Qualifications and clinical supervision:**

| | |
|---|---|
| 1. Post graduate qualification (minimum 2 years duration) in clinical psychology from an accredited university<br><br>**OR** | *(State degree, university, year conferred)* |
| 2. Post graduate qualification (minimum 2 years duration) in an area relevant to the practice of clinical psychology from an accredited university<br><br>**OR** | *(State degree, university, year conferred)* |
| 3. Psychologist with demonstrated supervised experience in relevant clinical practice areas equivalent to 5 years full time. | *(List positions where completed 5 years FTE experience)*<br><br>Position Organisation Hours/week Duration<br><br>1.________________________<br>2.________________________<br>3.________________________<br>4.________________________<br>5.________________________<br>6.________________________<br>7.________________________ |

**Essential Criteria - Professional Development:**

| | |
|---|---|
| Please give details if you are a member of an APS college<br><br>Evidence of professional development activities (including supervision) relevant to clinical practice undertaken in the past 2 years | ________________________<br><br>*(Attach separate sheet e.g. APS college log sheets)* |

**Essential Criteria – Clinical Supervision**

<table>
<tr><td>Evidence of supervision (by an experienced clinician - with minimum 5 years clinical experience) occurring monthly for a minimum of 2 years post registration</td><td>Hours of supervision    Duration (months/years)    Credentials of supervisor<br><br>1.________________    _________    ___________________<br>2.________________    _________    ____________________<br>3.________________    _________    ____________________<br><br>Name and daytime contact number(s) of supervisors:<br><br>1.__________________________________    ____________________________<br>2.__________________________________    ____________________________<br>3.__________________________________    ____________________________</td></tr>
</table>

**Essential Criteria - Training: (Post undergraduate degree)**

| Completion of minimum 6 months (26 hours) training course in counselling theory and practice | *(Please provide details of where and when you undertook the following training requirements)* |
|---|---|
| Completion of minimum 6 months (26 hours) training course in assessment and diagnosis | |
| Completion of minimum 12 months (52 hours) training course in evidence-based interventions for mental health problems | |

**Essential Criteria - Claims / Circumstances:**

a) Have any claims or complaints ever been made against you? Yes ☐ No ☐

b) Are you aware of any circumstances, which may result in a claim against you? Yes ☐ No ☐

c) Has any insurer ever declined, cancelled or imposed special conditions in relation to your liability insurance? Yes ☐ No ☐

d) Are you currently engaged in (or about to enter into) civil proceedings of either a professional or personal nature? Yes ☐ No ☐

e) Have you ever been subject to disciplinary proceedings for professional misconduct by a professional society or any statutory board or been called upon to respond to a complaint? Yes ☐ No ☐

f) Have you had a complaint in relation to previous SESDGP contracted work? Yes ☐ No ☐

g) Is there any other information about current or past circumstances that may be relevant for SESDGP to know in considering this application? Yes ☐ No ☐

If you answered yes to a), b), c), d), e), f) or g) please provide details on separate letterhead

**Essential Criteria - Working with Children Check:**

*(Please complete and sign the attached form and attach a photocopy of your current driver's license)*

**Essential Criteria - Referees:**

| Please provide the names/contact details of two referees (who have been professional colleagues and familiar with your work within the last 3 years) | 1. |
|---|---|
| | 2. |

I understand I will be required to produce, upon request, documentary evidence of my identity and stated educational achievements. I undertake to supply proof of current professional registration and current certificate of insurance on an annual basis. I declare that all the information supplied in this form is true and accurate to the best of my knowledge.

| Name: | Signature: | Date: |
|---|---|---|
| ______________________________ | ______________________________ | ___ / ___ / ___ |

**Desirable Criteria – areas of expertise:**

*Please **select those items** with which you are able to **demonstrate advanced levels of competency** (by way of training, skills & experience). **Please indicate your areas of expertise by placing the numbers 1-15 (maximum)** in the appropriate boxes. Only the first 10 will appear in the service directory available on the SESDGP website and in hardcopy directory for our GPs.*

| | | |
|---|---|---|
| Mental Health | ❑ Attention Deficit Hyperactivity Disorder<br>❑ Anxiety & phobias<br>❑ Asperger's syndrome<br>❑ Autism<br>❑ Depression<br>❑ Dissociative Identity Disorder | ❑ Eating disorders<br>❑ Gender / sexual disorders<br>❑ Mental illness<br>❑ Obsessive compulsive disorder<br>❑ Personality disorders<br>❑ Post-natal depression |
| General Health | ❑ Health related problems<br>❑ Infertility issues<br>❑ Pain management<br>❑ Rehabilitation / injury counselling | ❑ Relaxation<br>❑ Sleeping disorders<br>❑ Stress management<br>❑ Terminal illness<br>❑ Weight management |
| Trauma / Harm | ❑ Bullying<br>❑ Critical Incident stress Debriefing<br>❑ Cult involvement<br>❑ Physical abuse<br>❑ Post traumatic Stress Disorder | ❑ Self harm<br>❑ Sexual abuse<br>❑ Suicide<br>❑ Victim of crime |
| Personal | ❑ Anger management<br>❑ Assertiveness training<br>❑ Behavioural problems<br>❑ Gay / lesbian issues<br>❑ Grief / loss<br>❑ Life / personal coaching | ❑ Life transition & adjustment issues<br>❑ Motivation in sport<br>❑ Self esteem & self development<br>❑ Sexual difficulties<br>❑ Shyness &social skills deficits<br>❑ Sport performance anxiety |
| Relationships | ❑ Conflict resolution<br>❑ Couples therapy<br>❑ Cross-cultural | ❑ Divorce separation<br>❑ Parenting<br>❑ Relationships |
| Educational | ❑ Academic performance<br>❑ Intellectual assessment | ❑ Intellectual disability<br>❑ Learning difficulties |
| Addictions | ❑ Gambling<br>❑ Impulsive behaviours | ❑ Smoking cessation<br>❑ Alcohol abuse<br>❑ Substance abuse |
| Work / community | ❑ Community consultation / evaluation<br>❑ Employee assistance program<br>❑ Human resource management<br>❑ Leadership<br>❑ Organisational restructuring | ❑ Performance management<br>❑ Personnel selection<br>❑ Work stress<br>❑ Workplace bullying<br>❑ Workplace / executive coaching |
| Legal | ❑ Criminal behaviour<br>❑ Expert witness<br>❑ Family court issues | ❑ Legal report<br>❑ Management of offenders<br>❑ Sex offenders |

If you can treat other issues or syndromes, describe briefly below:

In the following sections there are no limits. You may mark as many items as you wish

| | | |
|---|---|---|
| Client type | ❑ Infant (0 – 1 years)<br>❑ Pre-school (2 – 4 years)<br>❑ Child (5 – 12 years)<br>❑ Adolescent (13 – 17 years) | ❑ Adult<br>❑ Older adult<br>❑ Couple<br>❑ Family |
| Provision of counseling in languages other than English | ❑ Mandarin / Cantonese (please circle)<br>❑ Vietnamese<br>❑ Korean<br>❑ Arabic | ❑ Greek<br>❑ Italian<br>❑ Portuguese<br>❑ Other(specify)<br>______________________ |

| |
|---|
| Please list any client exclusions: |

Do you provide bulk billing services? If so please describe eligible client types:

| | | |
|---|---|---|
| Please indicate the eligible client types for bulk billing services | ❑ All clients<br>❑ Financial hardship<br>❑ Low income, health care card holders<br>❑ Pensioners, on Centrelink benefits | ❑ Students<br>❑ Unemployed<br>❑ Other (specify)<br>______________________ |

| | | |
|---|---|---|
| What therapeutic approach(es) do you use? | ❑ CBT<br>❑ Family therapy<br>❑ Gestalt<br>❑ Humanistic<br>❑ IPT | ❑ Narrative<br>❑ Jungian<br>❑ Psychodynamic<br>❑ Solution focused brief therapy<br>❑ Other(specify)_______________________ |
| Other Interventions | ❑ Art therapy<br>❑ Biofeedback<br>❑ Clinical hypnosis<br>❑ EMDR<br>❑ Other (specify)___________________________________ | |

**Declaration:**
All information on this form is true to the best of my knowledge and I am competent to deal with the categories indicated above. I understand that my name, practice address, contact and professional details will be included in a directory available on the SESDGP website.

Name: ____________________________________ Signature: ________________________________ Date: ___ / ___ / ___