Statewide Obstetric Shared Care Program

GP Registration Form

Gender: M / F (Please circle)

Name: ……..DOB: ……...

Primary Practice Name: ……..

Primary Practice Address: ……..

Telephone: ……Fax:……. Email: ……...

Secondary Practice Name: ……..

Secondary Practice Address: ……..

QA No: ……ACRRM No:……..

Qualifications: ……

Obstetric Experience: CSCT (Yes / No) DRANZCOG or equivalent (Yes / No)

Please provide a limited Curriculum vitae outlining all details of any obstetric experience:
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……
……

I have current Indemnity Insurance (please ✓ appropriate box)

☐ non-procedural GP ☐ GP with full obstetric cover

I have knowledge and understanding of the Protocols for Shared Antenatal Care (see www.sadi.org.au). I wish to undertake Shared Care with the participating Hospitals or Obstetricians. I understand that I am required to attend relevant CPD to become accredited to the SOSCP.I understand that if I do not follow protocols or attend relevant CPD my accreditation status will be withdrawn.

Signed: …… Date……..