**A Medical Officer who wishes to undertake secondary employment through a Medical Locum Agency must complete this form and obtain the support of their supervisor/department head and the approval of their Local Health District/Specialty Network Chief Executive or delegate. An authorised copy of the completed form must be provided to a Medical Locum Agency on registration for locum work in a NSW Public Health Organisation.**

**Medical Locum Agencies must provide an authorised copy of an Approval for Secondary Employment form to a NSW Local Health District/Specialty Network Medical Workforce Unit together with pre-placement and credentialing documents in respect of any candidate who is a NSW Health employee and is put forward for locum work in a NSW Public Health Organisation.**

|  |  |
| --- | --- |
| **NSW Health employee and employment details** |  |
| **Stafflink no.** |  |  |  |  |  |  |  |  |  |  |
| **Surname** |  | **Given name(s)** |  |
| **Position number** |  | **Position title** |  |
| **Current facility/ service** |  | **Department** |  |
| **Local Health District/SN** |  | **Contact tel. no.** |  |
| **Brief description of substantive employment** |  |
|  |
| **Contracted hours of work per week** |  |
| **Hours of regular overtime per week** |  |
| **Total hours per day travelling to/from work per week** |  |

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| **Proposed secondary employment** |
| **Employer/casual pool/agency** |  |
| **Number of proposed hours per week** |  |
| **Preferred shifts per week** |  |
| **Preferred days** |  |
| **Brief description of proposed employment** |  |
|  |
| **Total hours per day travelling to/from proposed employment** |  |
| **Employee declaration** |
| I have read and understood the information provided with this form.I agree to comply with the NSW Health PD2015\_049 *Code of Conduct*, in particular, the standards set out in section 4.3 of the *Code of Conduct* regarding secondary employment. I agree to comply with the requirements of the NSW Health Policy Directive PD2015\_045 *Conflicts of Interest and Gifts and Benefits* in relation to secondary employment.I confirm that any secondary employment will be undertaken in my own time, will not adversely affect my substantive role, will not lead to a conflict of interest, use of Health Service resources or Health Service information and will not affect my work performance, safety or the safety of colleagues, patients, clients or the public. I confirm that my substantive employer has the right to review and cancel this arrangement at any time. |
| **Employee signature** |  |
| **Date** |  |

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| **Supervisor / Department Head** |
| Request not supported ⬜ for the following reasons: |
| Request supported ⬜ with the following conditions:Approval is granted until ………………………………………………………………………. (date).The hours worked in secondary employment should not exceed ………………….(number) per week.The employee must ensure that there is a gap of at least 8 hours for rest, excluding travel time, between shifts for any employer.The employee must maintain a record of hours worked and provide a copy of the record on request. |
| **Signature** |  |
| **Position** |  |
| **Date** |  |

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| --- |
| **Local Health District/Specialty Network Chief Executive, or delegate** |
| **Chief Executive name** |  |
| **Chief Executive signature** |  |
| **Delegate name** |  |
| **Delegate position** |  |
| **Delegate signature** |  |
| Request approved ⬜ | Request not approved ⬜ |  |