



## QUEEN ANNE STREET MEDICAL CENTRE

### Application for Admitting Rights

The information given by you on this form will enable the Hospital Manager to keep you well informed about Queen Anne St. Medical Centre and its services. Please print clearly, thank you.

Surname:	First names:	Initials	Title
Date of birth:		Speciality:	
Mobile number:		E-mail address:	
Do you hold a substantive NHS consultant appointment		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If no, have you ever held a substantive NHS consultant appointment		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If applicable, please provide reason for leaving NHS appointment:			
If applicable, please provide date of leaving NHS appointment:			
Current position held:			
Name of defence organisation or insurer:			
Registration Number/Insurance Policy Number:		Expiry Date:	(please supply proof of indemnity)
Specialist Register and number:			
GMC Revalidation Date:			
Please indicate the specific type of work you wish to practice here including procedures, techniques and treatment regimes.			

### Designated Body Information:

<b>Designated Body Name:</b>	
<b>Address:</b>	
<b>Postcode:</b>	
<b>Responsible Officer (R.O) Name:</b>	
<b>R.O's GMC Number:</b>	
<b>R.O's Contact number:</b>	<b>R.O's Email:</b>

## Contact addresses

NHS address			
Postcode:	Telephone no:	Fax no:	
Consulting rooms address			
Postcode:	Telephone no:	Fax no:	
Home address			
Postcode:	Telephone no:	Fax no:	
Preferred mailing address (please tick)	NHS <input type="checkbox"/>	Consulting rooms <input type="checkbox"/>	Home <input type="checkbox"/>

## Appraisal and Revalidation

Date of last revalidation:	
Date of next revalidation:	
Date of next appraisal:	

## Secretaries' details

Secretary's first name:	Surname:
Telephone No:	Email address:

## Please provide copies of the following:

- Full CV
- Evidence of registration of GMC Specialist register
- GMC Certificate
- DBS Enhanced Disclosure certificate
- Copy of Hepatitis B antibody and antigen status result (within the last 5 years)
- Evidence of radiation protection Training (if applicable)
- Evidence of MDU/MPS indemnity for Insurance purpose
- Form 4 of last NHS Appraisal or evidence of Career path development
- Bupa Accreditation
- Evidence of any relevant qualifications, accreditations and of CME/CPD
- Details of all equipment you are planning to bring into QASMC. If not bringing any equipment tick N/A
- Evidence of servicing/calibration of any equipment you are planning to bring into QASMC

**Referees**

**Please supply two references**

1.	Name _____	Position _____
	Address _____	
	_____	
	_____	
	Email _____	
2.	Name _____	Position _____
	Address _____	
	_____	
	_____	
	Email _____	

**DECLARATION:**

I declare that the information given by me in this form is true and accurate.

I also declare that I know of no circumstances which could lead to an allegation of serious professional misconduct or seriously deficient professional performance being brought against me by the General Medical Council or General Dental Council.

I apply for the grant by Queen Anne St. Medical Centre of practicing and/or admitting privileges at the Hospital on the basis of the terms of conditions set out which I agree shall be binding on me if Queen Anne St. Medical Centre grants me such privileges.

I consent to my name, clinical speciality, consulting room address and telephone number being included in the list of visiting consultants with admitting rights produced by Queen Anne St. Medical Centre, in accordance with the GMC permitted practice.

In order to protect health care workers and patients from Hepatitis B, I confirm that I have been immunised against Hepatitis B and I am not E-Antigen positive (HSG (93) 40).

I agree to provide training to QASMC staff on how to use any equipment I am bringing in.

I agree to arrange and pay for the cost of servicing/calibration of any equipment I am bringing in.

Signed \_\_\_\_\_ Dated \_\_\_\_\_