MEMBER REQUEST FOR ASSISTANCE

dentalprotection.org

Dental Protection

Please complete all of the fields below:

Membership number

Title

First name(s)

Surname

Dental Council registration number

Date of birth (DD/MM/YYYY)

Address

Postcode

Email address

Telephone number(s)

My query relates to:

Claim	**Ethical/legal dilemma**	**Medical Council issue**
Criminal investigation	**Generic medicolegal advice**	**Patient complaint**
Defamation	**Inquest**	**Other** (please advise below)

Period of involvement (date of earliest interaction and date of last interaction with patient relevant to the incident giving rise to case)

From (DD/MM/YYYY) to (DD/MM/YYYY)

Incident date (DD/MM/YYYY)

Private practice (tick as appropriate) Yes No

At the time of the incident, what was your Specialty?

At the time of the incident, what was your location?

At the time of the incident, what was your seniority/grade?

Name of hospital/clinic

Brief anonymised summary: (please detail below)

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Dental Protection Limited is registered in England (No. 2374160) and is a wholly owned subsidiary of The Medical Protection Society Limited (MPS) which is registered in England (No.36142). Both companies use Dental Protection as a trading name and have their registered office at Level 19, The Shard, 32 London Bridge Street, London, SE1 9SG. Dental Protection Limited serves and supports the dental members of MPS with access to the full range of benefits of membership, which are all discretionary, and set out in MPS's Memorandum and Articles of Association. MPS is not an insurance company. Dental Protection® is a registered trademark of MPS.

Patient initials

Patient year of birth (MM/YYYY)

Patient outcome

If applicable, patient date of death (DD/MM/YYYY)

Additional Information

If you have any additional documents that you wish to forward to us, it is not usually necessary to forward all the documents now. Please, however, keep these safe as they may be requested from you in the future.

To protect patient confidentiality, please ensure you do not provide us with any additional documentation which could allow a patient to be identified.

Important information (please tick)

I confirm that I have not included any information that would allow a patient to be identified.

Signature: (Please enter your initials to sign)

Date: DD/MM/YYYY (Please note must be current date)

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