DENTAL CARE PROFESSIONALS



0800 561 9000 (Mon - Fri: 8.00am - 6.30pm) | member.help@dentalprotection.org | dentalprotection.org

Please complete in BLOCK CAPITALS, sign and return to: Member Operations, Medical Protection Society, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK.

If your application for membership of MPS is approved, it will be dated from the day following receipt of your application unless you specify a later start date in the area provided:

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|---|---|---|---|---|---|---|---|

This form should not be submitted earlier than 8 weeks before your required start.

| Section A – Personal details | | | | |
|---|---|--|--|--|
| Title | Address in UK for correspondence | | | |
| First name | | | | |
| Surname | | | | |
| Previous name if any | | | | |
| Date of birth (DD/MM/YYYY) | | | | |
| Gender Male Female | | | | |
| GDC registration number | Postcode | | | |
| Degrees and diplomas | Email address | | | |
| | Daytime telephone | | | |
| Dental school | Evening telephone Mobile telephone | | | |
| Month and year of graduation (MM/YYYY) | | | | |
| Will any of your dental practice be carried out in Scotland? | Yes No | | | |
| (If yes will more than 50% of your clinical practice be carried out in So | cotland. Yes No | | | |
| If you are registered to practise in any other countries please state which: | | | | |
| Will all your professional practice be carried out in the Country in which you are applying for membership? | | | | |
| Yes No If No, please provide Country and full details (If n | necessary please continue on a separate sheet) | | | |
| Will you be involved in treating or providing advice to patients outside of t | the Country in which you are applying for membership? | | | |
| Yes No If Yes, please provide Country and full details (If r | necessary please continue on a separate sheet) | | | |
| | | | | |

Please read all of the important additional information provided



Membership guidance for your application for MPS membership. If you do not have these documents please let us know so that we can send them to you. Contact us by telephone on **0800 561 9000** or via email at member.help@dentalprotection.org

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Section B – Previous History 🌗 PLEASE READ THE IMPORTANT INFORMATION BELOW

In this section you must include details of any matter in which you have been named or involved. Please include any pending, unresolved or closed issues, even those already reported to MPS. If necessary please continue your answers on pages 9 to 11. Please note that failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

| 1. | Have you had any pro | ofessional indemni | ty/insurance before? | Yes (Please | e goto Q2) N | lo (Please go to Q3) |
|--|--|--|---|---|--|--|
| Please give the name of all other organisations and the dates during the last 10 years which you were a member or policyholder. If you were previously a member of MPS, please give your membership number and your full name at the t (fit has changed) | | | | | | |
| | Organisation | From DD/MM/YYYY | To DD/MM/YYYY | MPS number | Full Name | Other membership or policy number |
| | | | | | | |
| 3. | | employer, insurer o | | | | se exclude any period(s) ver YES please confirm the |
| | Yes No | | | | | |
| 4. | YES.) If you answer YE | S please confirm the | ical practice of more e dates and the reasor ining that has been un | n for any gap. Please al | | n doubt please indicate of any continuous |
| | Yes No | | | | | |
| 5. | | lease indicate YES.) İ | f you answer YES plea: | | | ew or had it withdrawn/ providing dates and |
| | Yes No | | | | | |
| 6. | | | or conditions includin u answer YES please p | | | |
| | Yes No | | | | | |
| 7. | a local level (i.e. with include: date of incide | i in your own practic ent, factual summary | e)? If you answer YES | please provide full det ent of your involvemer | ails of the complaint, country where the | as not been resolved at nt(s). The details must he case was lodged, name |
| | Yes No | | | | | |

| Yes | clude: | In the last 10 years have you been involved in any claim(s) for compensation or damages arising out of your profession practice regardless of the outcome? If you answer YES please provide full details of the complaint(s). The details must include the date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet) |
|---|--------------------|--|
| The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the was lodged, name of indemnifier and the current status of the incident(s). (If necessary please continue on a separate shee Yes No No Nave you ever been the subject of a disciplinary inquiry or had practice privileges refused/ withdrawn/ made condition a health care provider? If you answer YES please provide full details. The details must include: date of incident, factual sun of the event, the extent of your involvement, country where the incident(s) occurred, name of indemnifier, the final outcomindent and was this reported to the regulatory body (If necessary please continue on a separate sheet) Yes No No Have you ever been subject to any referral, complaint, inquiry, investigation or hearing by any regulatory, licensing or registration body? If you answer YES please provide full details. The details must include date of incident, factual summare event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the final country of the country of the case was lodged, name of indemnifier and the final outcome of the final country of the please continue on a separate sheet) Yes No Ave you been cautioned by the police or convicted of any criminal offence? (You do not need to include spent/expir convictions, or minor road traffic offences that did not involve alcohol or drugs.) If you answer YES please provide full to the regulatory body (If necessary please continue on a separate sheet) Yes No Are there any other issues of which MPS might reasonably need to be aware when considering your application for membership? (If in doubt please indicate YES.) If you answer YES please provide all relevant information below. (If necessar continue on a separate sheet) | | Yes No |
| a health care provider? If you answer YES please provide full details. The details must include: date of incident, factual sum of the event, the extent of your involvement, country where the incident(s) occurred, name of indemnifier, the final outcom incident and was this reported to the regulatory body (if necessary please continue on a separate sheet) Yes No 1. Have you ever been subject to any referral, complaint, inquiry, investigation or hearing by any regulatory, licensing or registration body? If you answer YES please provide full details. The details must include: date of incident, factual summar event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the final outcome or current position and was this reporter regulatory body (if necessary please continue on a separate sheet) Yes No 1. Have you been cautioned by the police or convicted of any criminal offence? (You do not need to include spent/expir convictions, or minor road traffic offences that did not involve alcohol or drugs.) If you answer YES please provide full of the regulatory body (if necessary please continue on a separate sheet) Yes No 1. Have you been cautioned by the police or convicted of any criminal offence? (You do not need to include spent/expir convictions, or minor road traffic offences that did not involve alcohol or drugs.) If you answer YES please provide all relevant position and was this reported to the regulatory body (if necessary please continue on a separate sheet) Yes No | ne case | The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the was lodged, name of indemnifier and the current status of the incident(s). (If necessary please continue on a separate sheet and the current status of the incident (s). |
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| Are there any other issues of which MPS might reasonably need to be aware when considering your application for membership? (If in doubt please indicate YES.) If you answer YES please provide full or membership? (If in doubt please indicate YES.) If you answer YES please provide full or the regulatory body (If necessary please continue on a separate sheet) Are there any other issues of which MPS might reasonably need to be aware when considering your application for membership? (If in doubt please indicate YES.) If you answer YES please provide all relevant information below. (If necessar continue on a separate sheet) | ry of the | registration body? If you answer YES please provide full details. The details must include: date of incident, factual summa event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of t |
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| membership? (If in doubt please indicate YES.) If you answer YES please provide all relevant information below. (If necessary continue on a separate sheet) | details. | convictions, or minor road traffic offences that did <u>not</u> involve alcohol or drugs.) If you answer YES please provide full The details must include: date of incident, full details of the offence, the final outcome or current position and was this report the regulatory body (If necessary please continue on a separate sheet) |
| Yes No | ry pleas: | membership? (If in doubt please indicate YES.) If you answer YES please provide all relevant information below. (If necessar |
| | | Yes No |

Section C - About You

| 1. Please tick below to indicate which best describes your position:: |
|---|
| Hygienist |
| Therapist |
| Orthodontic Therapist |
| Dental Nurse |
| Dental Technician |
| Clinical Dental Technician |
| First year qualified |
| If yes please state qualification and year gained |
| 2. Are you: |
| A Practice Owner |
| A Laboratory Owner |
| Working in a practice owned by somebody else |
| Working in a laboratory owned by somebody else |
| Are you applying for membership as part of a group scheme (eg employer indemnified arrangement)? |
| Are you applying for membership as part of a Dental Protection Xtra practice? |
| Yes No |
| If yes please provide the Dental Protection Xtra practice number and then go to section D. |
| Dental Protection Xtra number: |
| 3. Do you have a provider contract in your own name (or jointly with other people) with NHS England, LHB or similar NHS body? |
| Do you have any other responsibilities as a practice principal or laboratory owner? |
| Yes No |
| Do you employ or have employment responsibility for any other staff? |
| Yes No |
| Do you employ dental nurses or dental technicians? |
| Yes No |
| 4. How many dental nurses do you employ? Please provide details: |
| How many dental technicians do you employ? Please provide details: |
| Would you like the DCPs indicated above to be indemnified for clinical negligence within your own membership? |
| Yes No |
| |

Section D - Employer Indemnified

| This is only applicable for DCPs with indemnity provided by their employer who is either a full dental member of MPS paying the appropriate subscription rate or is part of the NHS Indemnity/Crown Indemnity scheme, who wish to purchase protection for matters additional to clinical negligence. |
|--|
| 1. Are you: |
| Employed |
| Self-employed |
| 2. If you are employed |
| Is your employer a dental member of MPS? |
| Yes No |
| If yes please state your employer's |
| Full name |
| GDC registration number |
| Dental Protection membership number |
| 3. Are you |
| Part of the NHS Indemnity / Crown Indemnity Scheme |
| Yes No |
| If yes are you employed in: |
| Hospital, University or as Dental School Staff |
| Community Service |
| HM Prison Service |
| HM Forces |
| Other, please give details |
| Please confirm your position: eg, Hygienist, Technician |
| Section E – Part time work only |
| If yes please provide details in Section F1. |
| 1. If you are a part-time DCP and wish to apply for a reduced subscription rate because your involvement in dentistry is limited, please tick below: |
| My current dental activity is up to & including 20 hours/week (1,000 hours/year) |
| Please note that total "involvement in dentistry" in the stated hours should take into account both clinical activity and any other involvement in dentistry (eg, advisory work, practice ownership, employment of other dentists or DCPs). |
| 2. Please describe your position |
| |
| |

Section F – Employed Dental Nurses and Dental Technicians

| 1. | We need the full name of each dental nurse/dental technician that you employ and for whom you wish to have the right to request indemnity against clinical negligence claims only through your own membership at no extra cost. |
|-------------|--|
| | Please underline the surname/family name. |
| | Name |
| | 1. |
| | 2. |
| | 3. |
| | 4. |
| | 5. |
| | Please note: Assistance may be requested for claims against the above named nurses/technicians through your practice principal membership for clinical negligence only. With the number of complaints and GDC investigations involving dental nurses and dental technicians on the rise and the fact that 80% of all our cases are not related to clinical negligence we recommend that dental nurses and dental technicians have full individual membership. |
| | The above named nurses/technicians can apply for full dental membership at a 50% discount, in order to provide them with personal indemnity in relation to professional matters other than negligence claims (for example, GDC complaints or investigations, inquests, criminal allegations etc). Alternatively they can be fully indemnified for free through the Dental Protection Xtra practice programme. |
| | For more information regarding membership for dental nurses/dental technicians or the Dental Protection Xtra programme go to dentalprotection.org or contact Member Services on 0800 561 9000 . |
| | Please ensure that you keep us informed of the names of any nurses/technicians who start or leave your employment, take maternity leave or other career breaks etc. |
| | |
| IM | PORTANT! – Your Personal Information and Data |
| race mer | en interacting with MPS, you may choose to give MPS information about your criminal convictions and offences (including alleged offences), your health, e, ethnic origin, sex life, sexual orientation and trade union membership ("Special Category Data"). This happens where that information is relevant to your mbership or the actual or potential provision of advice, assistance or indemnity. We may also receive Special Category Data about you from others in nection with membership or advice, assistance or indemnity (e.g. from a complainant, claimant, witness, expert, court or regulator). |
| | and out more about how we collect, use and handle your data including Special Category Data, please see the Privacy Statement on our website dicalprotection.org. |
| | en you tick the box below, you expressly consent to MPS processing your Special Category Data for the purposes of providing you with membership its benefits (including assistance and indemnity). |

You may withdraw consent to such processing by contacting MPS, but if you do so we will no longer be able to provide you with membership and

☐ I consent

its benefits.

| IMPORTANT! – Please read, sign and add the current of | date below. |
|--|--|
| By signing and returning this form, you agree and confirm that: You wish to apply for membership of MPS subject to the Memorandum and Articles of Association You understand that any failure to disclose full and accurate details may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership You understand that membership is not conferred automatically and is subject to approval by MPS You acknowledge that any subscription payments made are subject to verification and that acceptance of a payment by MPS does not of itself confirm membership and/or entitlement to request benefits You will inform us if your personal circumstances, scope of practice or other details (including in relation to income and number of sessions worked) change We may seek information from other professional defence organisations, insurance companies, employers, and/or other third parties in respect of membership and that they may release to us such information | Date Please note must be current date If you are submitting additional sheets or correspondence, please tick here Please check that you have completed a payment instruction form telling us how you would like to pay for your subscription and please tick here to confirm that the form is enclosed In order to provide you with the best possible service we would like to inform you of other products and services offered by us that we believe may be of interest to you. To opt-in to receive such information, either via post or email, please tick here You can update your marketing preferences by contacting us. Please remember to inform us promptly of any change to your personal |
| You have read the appropriate information for applicants guidance sheet Where did you learn about Dental Protection? 1. At dental school 2. Personal recommendation | circumstances or scope of practice. |
| Personal recommendation Mailing from Dental Protection Press advertising GDC A lecture/presentation Other (please provide details) | |
| Please tell us why you have chosen MPS – Your comm 1. Personal recommendation | ents are important to us, please tick below |
| Competitive subscription rates MPS membership co-ordinator, please provide their initials: Group arrangement Dissatisfaction with previous organisation Other (please provide details in the space provided) | |
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| Please clearly indicate the question number that, you are providing details for below. | Additional space for answers to Section B – Previous history |
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| Additional space for answers to Section B – Previous history |
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| Please clearly indicate the question number that you are providing details for below. |
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Dental Protection

Member Operations Victoria House 2 Victoria Place

Leeds, LS11 5AE

United Kingdom.

0800 561 9000 (Mon – Fri: 8.00am – 6.30pm)

Calls to Member Services may be recorded for training and monitoring purposes

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