ASSOCIATE MEMBERSHIP UK

Medical Protection

0800 561 9000 (Mon – Fri: 8.00am – 6.30pm) | **member.help@medicalprotection.org** | **medicalprotection.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: D D M M Y Y Y Y

Section A – Personal details

Title

First name

Surname

Previous name if any

Date of birth (DD/MM/YYYY)

Gender ☐ Male ☐ Female

Degrees/diplomas/qualifications

Month and year of graduation (MM/YYYY)

Address in UK for correspondence

Postcode

Email address

Daytime telephone

Evening telephone

Mobile telephone

What percentage of your clinical time is spent in England/Wales ☐ **Northen Ireland** ☐ **Scotland** ☐

If you are registered to practise in any other Country please state which:

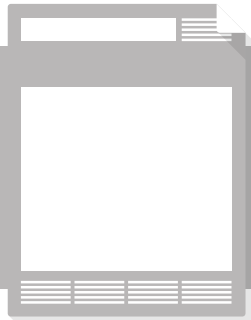
Will all your professional practice be carried out in the Country in which you are applying for membership?

☐ **Yes** ☐ **No** If No, please provide Country and full details (If necessary please continue on a separate sheet)

Will you be involved in treating or providing advice to patients outside of the Country in which you are applying for membership? (eg telemedicine)

☐ **Yes** ☐ **No** If Yes, please provide Country and full details (If necessary please continue on a separate sheet)

Please read all of the important additional information provided



Please read the relevant **Information for applicants** and **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@medicalprotection.org**

0005:11/18

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 6 to 7. 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 professional indemnity/insurance before?** ☐ **Yes** (Please goto Q2) ☐ **No** (Please go to Q3)

2. **Please give the name of all other organisations and the dates during the last 10 years which you were a member or policy-holder. If you were previously a member of MPS, please give your membership number and your full name at the time** (if it has changed)

Organisation	From DD/MM/YYYY	To DD/MM/YYYY	MPS number	Full Name	Other membership or policy number

3. **Have you at any stage practised without professional indemnity during the last 10 years (ie, please exclude any period(s) protected by state, employer, insurer or MDO indemnity)?** (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reasons below.

☐ **Yes** ☐ **No**

4. **Have there been any breaks in your clinical practice of more than 6 months in the last 2 years?** (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reason for any gap. Please also provide details of any continuous professional development or refresher training that has been undertaken.

☐ **Yes** ☐ **No**

5. **Have you ever previously been refused professional indemnity/insurance including a decline to renew or had it withdrawn/voided?** (If in doubt please indicate YES.) If you answer YES please provide a summary in your own words providing dates and reasons, including copies of any correspondence.

☐ **Yes** ☐ **No**

6. **Have you had any non-standard terms or conditions including a non-standard subscription or premium imposed on your professional indemnity/insurance?** If you answer YES please provide date and full details (If necessary please continue on a separate sheet)

☐ **Yes** ☐ **No**

7. **In the last 10 years, have you had any complaint(s) arising out of your professional practice which has not been resolved at a local level (ie, within your own practice)?** If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet)

☐ **Yes** ☐ **No**

If you have answered YES to any of the above questions please provide details as requested. Use pages 6 to 7 if needed. 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.

8. **In the last 10 years have you been involved in any claim(s) for compensation or damages arising out of your professional practice regardless of the outcome?** If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

9. **Are you aware of any incident(s) that might become a claim?** If you answer YES please provide full details of the incident(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the current status of the incident(s). (If necessary please continue on a separate sheet)

☐ Yes ☐ No

10. **Have you ever been the subject of a disciplinary inquiry or had practice privileges refused/ withdrawn/ made conditional by a health care provider?** If you answer YES please provide full details. The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the incident(s) occurred, name of indemnifier, the final outcome of the incident and was this reported to the regulatory body (If necessary please continue on a separate sheet)

☐ Yes ☐ No

11. **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 summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the case. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

12. **Have you been cautioned by the police or convicted of any criminal offence? (You do not need to include spent/expired convictions, or minor road traffic offences that did not involve alcohol or drugs.)** If you answer YES please provide full details. The details must include: date of incident, full details of the offence, the final outcome or current position and was this reported to the regulatory body (If necessary please continue on a separate sheet)

☐ Yes ☐ No

13. **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 necessary please continue on a separate sheet)

☐ Yes ☐ No

If you have answered YES to any of the above questions please provide details as requested. Use pages 6 to 7 if needed. 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.

About you

Are you involved in the treatment of elite/professional sportsmen or sportswomen? (See Information sheet)

☐ **Yes** (Please provide details below) ☐ **No**

Section C – Clinical scientists

1. For **Clinical Scientists** only Please tick the box that applies to you:

☐ **No NHS appointment**	☐ **Non-NHS earnings up to £7,500 pa (gross)**
☐ **NHS employed**	☐ **Non-NHS earnings more than £7,501 pa (gross)**
☐ **Trainee**	☐ **Carry out IVF procedures**

Section D – Primary care

1. Please tick the box below that applies to you:

☐ **Practice Manager**

☐ **Nurse Practitioner**

☐ **Practice Nurse**

2. Are you a partner? ☐ **Yes** ☐ **No**

3. **Roles and tasks**

a. Please provide your NMC (or equivalent) registration number:

To be eligible for membership of Medical Protection you must retain statutory registration with your professional body, or voluntary registration if you are a physician associate.

b. Do you undertake any Unscheduled care work? (See important notes below.) ☐ **Yes** ☐ **No**

c. Do you work part-time (3 days per week or less)? ☐ **Yes** ☐ **No**

Please tick the appropriate membership level (see information box below for guidance):

☐	**Level 4 membership**	Basic nursing duties, or a role undertaking tasks equivalent to a basic nurse.
☐	**Level 5 membership**	Any role undertaking any repeat prescribing, triage or management of patients with a chronic condition, in addition to level 4 tasks.
☐	**Level 6 membership**	Any role undertaking clinical assessment or management of patients with acute or undiagnosed conditions beyond initial triage, in addition to any level 4 and level 5 tasks

Please note: You should ensure that you only undertake tasks for which you are fully trained and competent to carry out. MPS does not provide indemnity for the practise of midwifery or for any cosmetic/aesthetic medicine treatments and/or procedures.

IMPORTANT NOTES – SCHEDULED AND UNSCHEDULED CARE

Scheduled care

Scheduled care is defined as work undertaken during the scheduled opening hours of the practice (Mon – Sun, 8.00am – 8.00pm) where registered patients are seen by appointment and where staff have access to the patient's full general practice records.

Unscheduled care

Unscheduled care is anything that falls outside of scheduled care. This includes care given at anytime in walk in / urgent care centres.

If you have answered YES to any of the above questions please provide details as requested. Use pages 6 to 7 if needed. 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.

Section E – Other Categories

3. Please tick the box below that applies to you:

- ☐ Medical Technical Officer
- ☐ Maxillo-facial Prosthetist/Technologist
- ☐ Surgical care practitioners/surgical assistants
- ☐ AODP (CODP) CODP membership number:

IMPORTANT! – Your Personal Information and Data

When interacting with MPS, you may choose to give MPS information about your criminal convictions and offences (including alleged offences), your health, race, ethnic origin, sex life, sexual orientation and trade union membership ("Special Category Data"). This happens where that information is relevant to your membership or the actual or potential provision of advice, assistance or indemnity. We may also receive Special Category Data about you from others in connection with membership or advice, assistance or indemnity (eg, from a complainant, claimant, witness, expert, court or regulator).

To find out more about how we collect, use and handle your data including Special Category Data, please see the Privacy Statement on our website **medicalprotection.org**.

When you tick the box below, you expressly consent to MPS processing your Special Category Data for the purposes of providing you with membership and its benefits (including assistance and indemnity).

☐ **I consent**

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 its benefits.

IMPORTANT! – Please read, sign and add the current 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
- You have read the appropriate information for applicants guidance sheet

Date D D M M Y Y Y Y **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 circumstances or scope of practice.

Additional space for answers to Section B – Previous history

Please clearly indicate the question number that you are providing details for below.

Additional space for answers to Section B – Previous history

Please clearly indicate the question number that you are providing details for below.

Please tell us why you have chosen MPS – Your comments are important to us, please tick below

1. ☐ Personal recommendation
2. ☐ Competitive subscription rates
3. ☐ MPS membership co-ordinator, please provide their initials:
4. ☐ Group arrangement
5. ☐ Dissatisfaction with previous organisation
6. ☐ Other (please provide details in the space provided)

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

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