Practice Membership application
New Zealand

Medical Protection

0800 225 5677 (Freephone) | nzpractice@medicalprotection.org | medicalprotection.org/practicemembership

Please complete all editable sections of this form electronically and return by email to the address above

Please provide practice details

Practice name	**Practice Membership number** (Office use only)
Practice address	
Postcode	Practice Membership is designed to make the benefits of Medical Protection membership available to GP practices.
Telephone	To apply to join Practice Membership please complete this form, return this to **nzpractice@medicalprotection.org**
Primary email address	
Secondary email address	

What is the legal status of your practice/organisation? (please select all that apply)

(Office use only

Practice Membership: Tier 1 ☐ Tier 2 ☐ Tier 3 ☐

- ☐ **GP partnership (either a single handed GP or a multiple partner practice)**
- ☐ **Limited Partnership**
- ☐ **Unincorporated Partnership**
- ☐ **Limited Liability Company**
- ☐ **Unlimited Company**
- ☐ **Cooperative Company**
- ☐ **Sole trader**
- ☐ **Trust**
- ☐ **Other** (please specify):

Please provide the full name of the organisation as registered at Companies Office:

Practice Membership details

Total GPs **Total GP FTE**

Total number of nurse practitioners **Total number of nurse prescribers**

Total number of registered nurses **Total number of enrolled nurses**

Please tell us the contractual arrangements under which you provide GP services (please select all that apply).

- ☐ **PHO**
- ☐ **ACC**
- ☐ **MOH**
- ☐ **Rest homes**
- ☐ **Well child/immunisations**
- ☐ **Other** (please specify):

211232875.01/22

Other details			
Is the practice designated as a training practice?	☐ **Yes**	☐ **No**	If **Yes**, please provide additional details below
Is the practice based on more than one site?	☐ **Yes**	☐ **No**	If **Yes**, please provide additional details below
Is the practice linked to any other practices?	☐ **Yes**	☐ **No**	If **Yes**, please provide additional details below
Trading since (dd/mm/yyyy)			

Contact details

Authorised person (primary contacts) Please provide details of the person authorised by the applicant to arrange, renew or vary the Practice Membership and to discuss any relevant details

Name

Title

Telephone

Email

Address (if different)

Signature

Contact details for additional authorised person

Name

Title

Telephone

Email

Address (if different)

Signature

Name of owner(s), director(s) who have a clinical role in the business and details of their professional experience and qualifications. If the applicant is not administered by the owner(s)/director(s), please outline the administrative structure. In particular state name, professional qualifications and years of experience.

Name and title	**Qualifications**	**Date qualified** (mm/yyyy)	**Years practicing**	**Name of previous practice** (if applicable)	**MPS membership number**	**Professional body** (please specify) registration number

Have any of your registered medical practitioners been suspended or removed from the relevant professional register, or had any claims or regulatory investigations in the last 10 years?

☐ **Yes** ☐ **No** If **Yes**, please provide further details

Please complete the table below in respect of all registered medical practitioners who work for the applicant, whether employed, sub-contracted, locum, volunteer or other. Please include, GPs, nurse practitioners and all nurses.

Name	**MPS membership number** (if already a member)	**Professional status**	**Employee status**	**Average number of weekly hours worked**

Please confirm the applicant checks and records indemnity/insurance arrangements regularly for all practitioners and that current indemnity/insurance is in place

☐ **Yes** ☐ **No**

Please complete the table below detailing the staff employed or contracted within the practice

*FTE means full-time equivalent. A full-time staff member is deemed to work 40 hours per week. You may have several members working part-time whose hours, when added together, equal 1 FTE.

Associate type	**FTE staff numbers**
Nurse practitioner	
Nurse prescriber	
Registered nurse	
Enrolled nurse	
Health care assistant	
Undergraduates or student staff	
Other medical, health or allied employees (please specify role type)	
Clerical or administrative	

Practice Membership

Does the practice presently hold indemnity/malpractice insurance

☐ **Yes,** MPS

☐ **Yes,** another provider (please state provider)

☐ **No**

Have you or any owner or director ever had a liability indemnifier/insurer decline a proposal or application or impose any non-standard terms or conditions (including enhanced subscription/premium)**?**

☐ **Yes** ☐ **No** If **Yes**, please provide details

Have you or any owner or director ever had a renewal declined or had insurance/indemnity cancelled by the provider?

☐ **Yes** ☐ **No** If **Yes**, please provide details

Please state your patient population

Please state the size of your registered patient list

Can you confirm that there are documented policies and procedures in place for the following:

Formal Complaints Procedure ☐ **Yes** ☐ **No**

Reporting and investigating adverse incidents ☐ **Yes** ☐ **No**

Claims and circumstances

Please provide details of any matter in which the practice have been named or involved in including any that we may already be aware of. Failure to disclose full and accurate details may delay your application and/or if accepted into membership could result in the suspension or withdrawal of membership benefits and/or termination of membership

During the past 10 years has any claim been made, settled or defended, or has malpractice or negligence been alleged, against the practice or any present or former director/owner. Have any circumstances been notified to indemnifiers/insurers which may result in a claim?

☐ **Yes** ☐ **No** If **Yes**, please provide details

Are there any circumstances not already notified to indemnifiers/insurers which may give rise to a claim against the applicant or practice?

☐ **Yes** ☐ **No** If **Yes**, please provide details

Are there any claims against previous practices which have been identified, which may give rise to a claim against the applicant or practice or owner/director?

☐ **Yes** ☐ **No** If **Yes**, please provide details

Has any practice, director, owner or staff member been subject to professional disciplinary or regulatory proceedings or criminal prosecution?

☐ **Yes** ☐ **No** If **Yes**, please provide details

Record keeping

Do you maintain accurate descriptive records of all medical services and equipment used in procedures?

☐ **Yes** ☐ **No**

If you are responsible for storing and disposing of medical records, do you ensure this is done in line with official guidance on managing records, including the retention schedule published by the relevant professional bodies?

☐ **Yes** ☐ **No**

Do you maintain a record of all requests on behalf of patients for medical records?

☐ **Yes** ☐ **No**

If **No**, to any of the above questions please provide details

Is there any further information that you are aware of that might affect our estimate of risk or decision to grant Practice Membership?

☐ **Yes** ☐ **No** If **Yes**, please provide details

Additional space for answers

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

Important – Data Protection information

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/privacy**

Please tick the following box to confirm that you have read the above declaration (and any accompanying guidance). ☐

Important – Please read the following information

Please note – this application should be approved and submitted by a duly authorised representative and dated. Any delay in returning after signing invalidates this application. If all applicable sections are not completed fully, this will delay the processing of your application.

Signed

Date of application (dd/mm/yyyy)

Print name

Position

For and on behalf of (practice name)

If your application is approved it will be dated from the day following receipt of your application, unless you specify a later start date in the box (dd/mm/yy).

By applying for MPS membership, you confirm you understand that membership of MPS is subject to:

- Approval and is not conferred automatically
- Payment of the appropriate subscription
- MPS's Memorandum and Articles of Association as amended from time to time, and that all benefits are granted at the discretion of MPS's council.
  - You confirm that you are, and will remain duly licensed, in accordance with the law to practice at the address specified on page 1 of the form.
  - You confirm that all staff are fully trained and competent for the work they undertake and properly supervised
  - You confirm that all medical records will be made available for inspection and use, without charge, by us or our appointed representatives together with any oral or written information, assistance, signed statements, evidence or depositions as required in the investigation or defence of any case or claim
  - You confirm the practice only undertakes activity within the normal scope of a General/Primary Care Practice and that all activities are undertaken within the New Zealand jurisdiction/no cross border telehealth services.
  - You confirm that the practice does not undertake any aesthetic cosmetic practice (unless specifically disclosed to us) or obstetric practice other than the normal shared ante natal care routinely undertaken within primary care?
  - You acknowledge that MPS is not an insurance company and that the benefits of membership are discretionary
- You warrant that all information provided to MPS:
  - i) is true, accurate and complete in all aspects
  - ii) has been collated and sent by a properly authorised person.

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 coordinator, please provide their initials:	
4.	☐	Group arrangement/practice membership	
5.	☐	Dissatisfaction with previous organisation	
6.	☐	Other (please provide details)	

Medical Protection

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