

# Membership application

## State employed – South Africa



0800 225 677 toll free | mps@samedical.org | medicalprotection.org

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

Alternatively please print out and complete using BLACK INK and BLOCK CAPITALS and return by post to:  
Block F, Castle Walk Corporate Park, Nossob Street, Erasmuskloof Ext3, Pretoria, 0181, South Africa

### Section A – Membership start date and personal details

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 box to the right: (DD/MM/YYYY)

Title		Country of permanent residence	
First name		Address for correspondence	
Middle name(s)			
Surname		Postcode (zip or postal area)	
Maiden/previous name (if any)		Email address	
Date of birth (DD/MM/YYYY)		Home/private telephone	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Work telephone	
ID Number		Cell number	
<b>Medical Council registration number – your application may be delayed if this is not provided</b>			

Please list your primary qualification and any additional qualifications below

Country of study	School/place of study	Qualification	Month and year obtained

### Section B – Practice overview

Please select below the grade which is most appropriate for your practice.

- Intern Year 1**  
No private/unindemnified practice allowed (private practice is against HPCSA regulations) – INT
- Intern Year 2**  
No private/unindemnified practice allowed (private practice is against HPCSA regulations) – I2N
- Community Medical Officer**  
No private/unindemnified practice allowed (private practice is against HPCSA regulations) – COM
- Grade 1 Medical Officer**  
No private/unindemnified practice, no locum work – SMF
- Registrar**  
No private/unindemnified practice, no locum work – REG
- Category 1**  
No private/unindemnified practice (including locum work and assisting), includes specialists and grade 2 and 3 medical officers – NPP

**IMPORTANT** – Please note that we expect doctors who are either employed by the state, or work in the the state, to be protected for claims by state/employer indemnity. Medical Protection does not include claims indemnity for state doctors. Please tick the box below to acknowledge this. If you do not complete the section below we will not be able to process your application.

I understand that my Medical Protection membership will not provide indemnity for claims.

**Section C – 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 the enclosed pages. 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?**  
 If YES, 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 time (if it has changed).  Yes  No

Organisation	From date (DD/MM/YYYY)	To date (DD/MM/YYYY)	Membership/policy number

**2. Will you carry out professional practice outside of the country in which you are applying for membership?** If YES, please give details of which countries and the amount of work below.  Yes  No

**3. Will you be involved in treating or providing advice to patients outside of the country in which you are applying for membership?** This includes remote consultation and prescriptions, if YES, please give details.  Yes  No

**4. Have you at any stage practiced without professional indemnity during the last 10 years?** If YES, please confirm the dates and the reasons below. Please exclude any period(s) protected by state, employer, insurer or MDO indemnity.  Yes  No

**5. Have there been any breaks in your clinical practice of more than 6 months in the last 2 years?** If YES, please confirm the dates and reason for the gap along with any continuous professional development or refresher training.  Yes  No

**6. Have you ever previously been refused professional indemnity or insurance, including a decline to renew, or had it withdrawn/voided?** If YES, please give a summary of events, dates and reasons below. Please include copies of any relevant correspondence.  Yes  No

**7. Have you had any non-standard terms or conditions including a non-standard subscription or premium imposed on your professional indemnity or insurance?** If YES, give a summary including events, dates and reasons.  Yes  No

**8. In the last 10 years, have you had any complaints arising out of your practice that were not resolved at a local level?** If YES, please give a factual summary of the event, the extent of your involvement, the country, relevant indemnifiers and outcomes.  Yes  No

**9. 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 YES, please give a factual summary, your involvement, indemnifiers and outcomes.  Yes  No

**10. Are you aware of any incident(s) or complaint that might become a claim?** If YES, please give a factual summary of the event, the extent of your involvement, the country, relevant indemnifiers and outcomes.  Yes  No

**11. Have you ever been the subject of a disciplinary inquiry or had practice privileges refused/withdrawn/made conditional by a health care provider?** If YES, please give details below. Please include copies of any outcome letters/documentation with your application.  Yes  No

**12. Have you ever been subject to any referral, complaint, inquiry, investigation or hearing by any regulatory, licensing or registration body?** If YES, please give details below. Please include copies of any outcome letters/documentation with your application form.  Yes  No

**13. Are there any other issues of which MPS might need to be aware when considering your application for membership?** If YES, please give details below.  Yes  No

**14. Have you been cautioned by the police or convicted of any criminal offence?** If YES, please give details below. Please do not include minor traffic offences.  Yes  No

**IMPORTANT – If you have answered Yes to any of the above questions please complete the following giving details as outlined in the question above. Please DO NOT provide patient sensitive or confidential information such as patients name and address information**

Question no.	Date	Outcome	Cost	Summary (please refer to the question above for what information is needed)

**Section D – Declaration**

**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/privacy](http://medicalprotection.org/privacy)

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:

- i. You wish to apply for membership of MPS subject to the Memorandum and Articles of Association.
- ii. 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.
- iii. You understand that membership is not conferred automatically and is subject to approval by MPS.
- iv. 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.
- v. You will inform us if your personal circumstances or scope of practice change.
- vi. 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.
- vii. For the purposes of the South African law and The Protection of Personal Information Act (4 of 2013), we may obtain, process, retain and transfer your personal data as set out in the Privacy Statement on our website [medicalprotection.org/privacy](http://medicalprotection.org/privacy)

Date

Please note this must be the current date

Tick here if you are submitting additional sheets or correspondence.

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 contact us to update your marketing preferences.

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

- |    |                          |                                                             |
|----|--------------------------|-------------------------------------------------------------|
| 1. | <input type="checkbox"/> | Personal recommendation                                     |
| 2. | <input type="checkbox"/> | Competitive subscription rates                              |
| 3. | <input type="checkbox"/> | MPS membership co-ordinator, please provide their initials: |
| 4. | <input type="checkbox"/> | Group arrangement                                           |
| 5. | <input type="checkbox"/> | Dissatisfaction with previous organisation                  |
| 6. | <input type="checkbox"/> | Other (please provide details)                              |



**Medical Protection – South Africa**

A scheme of co-operation between Medical Protection and SAMA South African Medical Association

Block F, Castle Walk Corporate Park  
Nossob Street, Erasmuskloof Ext3  
Pretoria, 0181, South Africa

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F 086 635 8810

[medicalprotection.org](http://medicalprotection.org)  
[mps@samedical.org](mailto:mps@samedical.org)

**Additional space for answers**

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