APPLICATION FORM

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| --- | --- | --- | --- | --- | --- |
| Associate Member | ☐ | AVS | ☐ | Project/other work-stream | ☐ |

|  |  |
| --- | --- |
| **Name:** | **Date of Birth:** |
| **Practice:** |
| **Home Address:** | **Home Phone:** |
| **Home Fax:** |
| **Mobile:** |
| **Other:** |
| **Preferred Email Contact:** |
| **Preferred Contact Details** (please circle one):This will be used for ALL postal contact | Home | Practice |
| **Performers List:** | **Date of Last Appraisal:** |
| **GMC No:** | **GMC Expiry Date:** |
| **Defence Org:** | **Defence Org Expiry Date:** |
| **Main in Hours Work:** GP Principal Salaried GP Associate / Assistant Locum Other (please specify)  |
| **Specialist Skills** (please tick any that apply to you): |
|  Active A & E Experience |  Anaesthetics |  ALS |  Section 12 |  Specialist GP |
|  Trained Reg Supervisor |  BASICS |  Paed ALS |  GP Trainer |  Police Surgeon |
|  Other (please specify)  |
| **Name & email address of referee** (must be current Shropdoc Member): |
| **Declaration of Health**I confirm that I have no medical condition that could affect my judgment or performance (including undue fatigue) when working Out of Hours. Shropdoc reserves the right to send home any GP who is (or appears to be) suffering from a medical condition that could be passed on to patients or co-workers, or intoxicated or unduly fatigued such that patients or co-workers may question my judgment or performance. I also agree that should I subsequently be offered any Membership status that if my health changes, which may affect my performance that I will advise Shropdoc in writing. I understand that Shropdoc will then have the right to review my Service Agreement and shift allocation accordingly.Signed………………………………………………………Date …………………………………………………….. |
| **Basic Training and Performance**(Please advise the dates of your latest training/updates in the following areas)BLS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Safeguarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Heb B Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Palliative Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

I declare that the answers given in this form are true and complete to the best of my knowledge and belief.

I attach copies of:

* Current Indemnity certificate
* Proof of performers list registration ( if applicable)
* Evidence of completion of IG training within the proceeding 12 months

 <https://nhsdigital.e-lfh.org.uk/> - please use the link to complete IG training e learning module (Data Security Awareness Level 1) if you are unable to evidence from your practice

* Evidence of **a** **current** **Enhanced DBS** (within last **6** months). If you are unable to provide, we can obtain for you for £65.38. We would need to see three pieces of original personal ID and verify it is you in person. Once the DBS is obtained, we recommend you then use the DBS update service. This has to be joined within 19 days of the new DBS application being received and is then an annual on-going update checking service for £14 pa, which means that you will never have to apply for a DBS again.

Signed …………………………………………………… ……Date …………………………………………

**For Office Use Only**

Interview Waiting List Unsuccessful

Signed ……………………………………………………………. Position …………………………….......

Date………………………………….