



**MEDICAL MALPRACTICE APPLICATION FORM**

SECTION 1		
Name:	Surname:	
Title:	Date of Birth:	
Home Address:	Work Address:	
Home Number:	Work Number:	Mobile Number:
Email address:		

SECTION 2		
Please advise which area(s) of medicine you are qualified and licensed to practice:		
Please provide your GMC number :		
How many years experience do you have in your surgical speciality?		
Please provide the % breakdown of your private work between the following categories:		
Type of Practice	Employed %	Self-employed %
Own private practice in a private hospital	.....	.....
Own practice in NHS hospital	.....	.....
Gross Annual Income from Private Practice?		
What % of your Income is generated from Consultations?		
Do you plan to retire in the next 5 years?		
Yes <input type="checkbox"/>		
No <input type="checkbox"/>		
Do you undertake work on any high profile clients e.g. Sports personalities, celebrities etc. or professional sports clubs?		
Yes <input type="checkbox"/>		
No <input type="checkbox"/>		
Are you aware of any complaints, claims or circumstances that have been brought or threatened against you, or any incident which could lead to such a complaint, claim or circumstance?		
If "yes" please provide details on an additional sheet.		
Yes <input type="checkbox"/>		
No <input type="checkbox"/>		



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Have you ever been subject to suspension from practice or any form of disciplinary action? If "yes" please provide details on an additional sheet.  Yes <input type="checkbox"/>  No <input type="checkbox"/>
Date cover required:
Existing Provider:

Signature: ..... Date: .....

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