SECTION 1:

Medical Practitioners (Registration) (Jersey) Law 1960
Application for registration as a medical practitioner

To be completed by all applicants who intend to practise as a medical practitioner in Jersey.

1. Personal Details

1.1. Full name with which you are registered with the GMC

Forename/s	Surname

1.2. Gender: Male ☐ Female ☐

1.3. Date of birth: ☐☐ ☐☐ ☐☐☐☐

1.4. Address at which you are registered with the GMC:

Postcode _____

1.5. Contact: Tel No _____ Home/Work/Mobile (delete as necessary)

Email address _____

2. Professional Qualifications

Please list your professional qualification/s including any post-graduate qualification/s (please continue on a separate sheet if required)

Qualification	Awarding Institution (name and location)	Year of qualification

3. Professional Registration

3.1. Date of first registration with the GMC: ☐☐ ☐☐ ☐☐

3.2. GMC Registration Number: ☐☐☐☐☐☐☐☐

3.3. Date of next GMC Revalidation: ☐☐ ☐☐ ☐☐

3.4. Date GMC retention fee due: ☐☐ ☐☐ ☐☐

3.5. Please provide details of any conditions imposed by the General Medical Council upon you, or any undertakings given by you, in connection with your registration under the UK Medical Act 1983 or your licence to practise:

(please continue on a separate sheet if required)

4. Medical Services Provision

4.1. Do you intend to work as a doctor in Jersey: **A.** Permanently ☐ or **B.** for a fixed period of time ☐

4.2. If **B**, please state the approximate dates that you intend to provide a medical service in Jersey:

Start	End

4.3. If you also practise in another jurisdiction which requires you to hold a GMC licence to practice, please provide the full name and contact address of your responsible officer or suitable person:

4.4. Do you intend to provide medical services in Jersey on a **self employed** basis? Yes ☐ No ☐

If **yes**, please provide the address details for the premise/s from where you will provide self employed medical services (please continue on a separate sheet if necessary):

1.

2.

4.5. Please provide the name, address and email address for each employer and/or each company, partnership or other entity for whom you intend to provide a medical service in Jersey as an employee, director, partner or other officer (please continue on a separate sheet if necessary):

Name	Full Address	Email Address

4.6. Please advise whether you consent to the details of the businesses where you provide medical services in Jersey being included in the publicly available list of medical practitioners.

Yes ☐ No ☐

5. Disclosure

5.1. Have you at any time, in Jersey, the UK or anywhere else in the world, been subject to any investigation which had an adverse outcome as follows:

1. an investigation regarding any matter relating to fraud. Yes ☐ No ☐
2. an investigation by any licensing, regulatory or other body into your professional conduct. Yes ☐ No ☐
3. an investigation by any current or former employer into your professional conduct or performance. Yes ☐ No ☐

Have you ever been convicted of an offence in Jersey, or elsewhere Yes ☐ No ☐

If you have answered **Yes** to any of the aforementioned questions, please provide details, including approximate dates, of where any investigation or proceedings were brought, the nature of the investigation or proceedings, and the outcome, or details of the conviction below:

(please use additional paper if required, ensuring all pages are numbered and signed)

5.2. To the best of your knowledge, are you currently, in Jersey, the UK or anywhere else in the world:

1. subject to an investigation into, or proceedings regarding your professional conduct by any licensing, regulatory or other body, including any investigation into, or proceedings regarding any matter relating to fraud? Yes ☐ No ☐
2. subject to an investigation into, or disciplinary proceedings regarding your professional conduct by an employer? Yes ☐ No ☐
3. subject to an investigation or proceedings which might lead to you being convicted of an offence in Jersey, or elsewhere Yes ☐ No ☐

If you have answered **Yes** to any of the aforementioned questions, please provide details, including approximate dates, of where any investigation or proceedings are to be brought and the nature of the investigation or proceedings, below:

(please use additional paper if required, ensuring all pages are numbered and signed)

6. Declaration

To the best of my knowledge, information and belief, the information provided in this application is true and complete. I understand that any false statements may provide grounds for the refusal of my application to be registered, or if discovered post registration, the cancellation of my registration.

Please note, on receipt of your application we will invoice you for the registration fee of £150.

Signed: _____

Date: _____

Application checklist:

Have you:

- Completed all relevant sections ☐
- Signed and dated the declaration ☐

Enclosed:

- your GMC certificate of proof of entry on the register (can be downloaded by you) ☐
- a copy of your photographic ID ☐

Please return this completed form to:
Jersey Care Commission
2nd Floor, 23 Hill Street
St. Helier
JE2 4UA

Fax to 01534 445773 or scan and email to notifications@carecommission.je

If you have any queries, please contact Mandy Bates (01534 445801) or Sally Hazley (01534 445802) or email enquiries@carecommission.je

SECTION 2:

Health Insurance (Performers List for General Medical Practitioners) (Jersey) Regulations 2014

Application for inclusion on Performers List

Only to be completed by general practitioners applying for approval under the Health Insurance (Jersey) Law 1967

The information provided in Section 1: Application for registration under the Medical Practitioners (Registration) (Jersey) Law 1960 will also be considered in determining this application.

In addition to this information, you are also required to provide proof that you have in place appropriate medical indemnity and a Criminal Record Certificate (issued not more than 6 months ago).

Please note that the Primary Care Governance Team should be notified, in writing, of any change or addition to the information provided, as soon as reasonably practicable, prior to the application being determined.

1. Have you previously been awarded temporary inclusion in the Jersey performers list? Yes ☐ No ☐
If yes, please give details:

2. Professional Experience
Please state, in chronological order, details of your professional experience (including the starting and finishing dates of each appointment. Please include experience in general practice, hospital appointments and any other professional experience along with the reason for leaving each post and the reasons for any dismissal. (Please use a separate sheet if required)

Name and full address of practice/hospital	From	To	Post held (including speciality and grade)	Reason for Leaving

2.1. Have there been any gaps in your employment? Yes ☐ No ☐
If yes, please provide details:

2.2. Other relevant/professional experience

Appointment/relevant experience	From	To

2.3. Have you ever been dismissed from a post? Yes ☐ No ☐
If yes, please provide details:

3. Performers Lists

To the best of your knowledge, are you currently subject to an investigation or proceedings which may lead to your disqualification, removal or suspension from an equivalent list? Yes ☐ No ☐
If yes, please provide details:

3.1. Do you have any outstanding applications, including any deferred applications, to be included on an equivalent list? Yes ☐ No ☐
If yes, please provide details:

3.2. Have you ever been removed from, refused inclusion on or included subject to conditions on an equivalent list? Yes ☐ No ☐
If yes, please provide details:

3.3. Are you currently suspended from an equivalent list? Yes ☐ No ☐
If yes, please provide details:

3.4. Have you ever been subject to a national disqualification? Yes ☐ No ☐
If yes, please provide details:

4. Referees

Please provide details for two referees **who are willing** to provide CLINICAL references relating to **two recent posts** (which may include any current post), as a performer, which lasted at least three months without a significant break. Where this is not possible, please give a full explanation (please use a separate sheet ensuring it is signed) and provide alternative referees.

Name		Name	
Title		Title	
Full postal address and postcode		Full postal address and postcode	
Contact telephone number		Contact telephone number	
Email address		Email address	

Period of acquaintance (month/year)	Period of acquaintance (month/year)
☐☐ ☐☐☐☐	☐☐ ☐☐☐☐
to	to
☐☐ ☐☐☐☐	☐☐ ☐☐☐☐

Consent
By signing the declaration below, I consent to a determining officer requesting from:

i. Any employer or former employer
ii. Any partnership in which I have declared I am, or was, a partner or any other company or other entity of which I am, or was a director or other officer, or
iii. From any body that licences or regulates the practice of medicine

any information relating to any current investigation or a past investigation where the outcome was adverse.

Declaration
To the best of my knowledge, information and belief, the information provided is true and complete, and that I shall as soon as is reasonably practicable inform Primary Care Governance Team in writing of any change or addition to the information supplied and submitted.

Signed: _____ Date: _____

Please include with your application, the following documentation:

- Appropriate Medical Indemnity
- Criminal Record Certificate (issued not more than 6 months ago)

SECTION 3:

Health Insurance (Medical Benefit) (General Provisions) Law 1967
Application to access the Health Insurance Fund

To be completed by all general practitioners who intend to access the Health Insurance Fund for prescribing purposes

I authorise my contact details and GMC registration number be forwarded to the Social Security Department in order that they can contact me to arrange an induction. This induction will contain important information about the Health Insurance Fund, Medical Benefit and the role of Approved Medical Practitioners in Social Security processes.

Signed: _____ Date: _____