Health and Community Services Department

Primary Care Governance Team

Application for inclusion in the Jersey Performers List

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

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. Telephone Number _____ home/work/mobile (delete as necessary)

Email address _____

2. Have you previously been awarded temporary inclusion in the **Jersey Performers List**?

Yes ☐ No ☐

If yes, please give details:

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. Please provide the full name and contact details for your **Responsible Officer** or Suitable Person:

3.5 Your last appraisal date: ☐☐ ☐☐ ☐☐

3.6 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 ☐ Your intended start date: _____

B. for a fixed period of time ☐

Start date	End date

4.2. 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

4.3. 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. 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

6. 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

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

6.2. Other relevant/professional experience

Appointment/relevant experience	From	To

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

7. Performers Lists

7.1. 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:

7.2. Do you have any outstanding applications, including any deferred applications, to be included on an equivalent list? Yes ☐ No ☐

If yes, please provide details:

7.3. 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:

7.4. Are you currently suspended from an equivalent list? Yes ☐ No ☐

If yes, please provide details:

7.5. Have you ever been subject to a national disqualification? Yes ☐ No ☐

If yes, please provide details:

8. Disclosure

8.1 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)

8.2. 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)

9. 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) From ☐☐ ☐☐☐☐ To ☐☐ ☐☐☐☐		Period of acquaintance (month/year) From ☐☐ ☐☐☐☐ 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.

☐ 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.

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: _____

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 you Jersey Medical Practitioner Registration Certificate obtained from the Jersey Care Commission ☐
- a copy of your photographic ID ☐
- a copy of your criminal record check (issued in the last 6 months) ☐
- A copy of you medical indemnity certificate (to cover the Channel Islands) ☐

PLEASE NOTE: IF THIS FORM IS INCOMPLETE OR RETURNED WITHOUT THE REQUIRED DOCUMENTATION, YOUR APPLICATIONO WILL BE DELAYED.

Please return this completed form to:

Primary Care Governance Team
Maison Le Pape
The Parade
St. Helier
JE2 3PU

Or via email to pcgt@health.gov.je