DENTISTS AND ORAL & MAXILLOFACIAL SURGEONS UK

Dental Protection

0800 561 9000 (Mon – Fri: 8.00am – 6.30pm) | **member.help@dentalprotection.org** | **dentalprotection.org**

Please complete in BLOCK CAPITALS, sign and return to: **Member Operations, Medical Protection Society, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK.**

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 area provided:

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This form should not be submitted earlier than 8 weeks before your required start.

Section A – Personal details

Title

First name

Surname

Previous name if any

Date of birth (DD/MM/YYYY)

Gender ☐ Male ☐ Female

GDC registration number

Degrees and diplomas

Dental school

Month and year of graduation (MM/YYYY)

Address in UK for correspondence

Postcode

Email address

Daytime telephone

Evening telephone

Mobile telephone

Will any of your dental practice be carried out in Scotland? ☐ Yes ☐ No

(If yes will more than 50% of your clinical practice be carried out in Scotland. ☐ Yes ☐ No

If you are registered to practise in any other countries please state which:

Will all your professional practice be carried out in the Country in which you are applying for membership?

☐ Yes ☐ No If No, please provide Country and full details (If necessary please continue on a separate sheet)

Will you be involved in treating or providing advice to patients outside of the Country in which you are applying for membership?

☐ Yes ☐ No If Yes, please provide Country and full details (If necessary please continue on a separate sheet)

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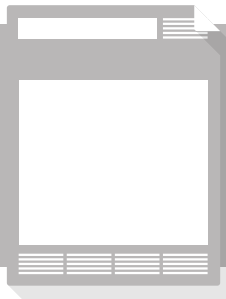
Please read all of the important additional information provided



Please read the relevant **Information for applicants** and **Membership guidance** for your application for MPS membership. If you do not have these documents please let us know so that we can send them to you. Contact us by telephone on **0800 561 9000** or via email at **member.help@dentalprotection.org**

Section B – 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 pages 9 to 11. 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?** ☐ **Yes** (Please goto Q2) ☐ **No** (Please go to Q3)

2. **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)

Organisation	From DD/MM/YYYY	To DD/MM/YYYY	MPS number	Full Name	Other membership or policy number

3. **Have you at any stage practiced without professional indemnity during the last 10 years (i.e. Please exclude any period(s) protected by state, employer, insurer or MDO indemnity)?** (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reasons below.

☐ Yes ☐ No

4. **Have there been any breaks in your clinical practice of more than 6 months in the last 2 years?** (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reason for any gap. Please also provide details of any continuous professional development or refresher training that has been undertaken.

☐ Yes ☐ No

5. **Have you ever previously been refused professional indemnity/insurance including a decline to renew or had it withdrawn/voided?** (If in doubt please indicate YES.) If you answer YES please provide a summary in your own words providing dates and reasons, including copies of any correspondence.

☐ Yes ☐ No

6. **Have you had any non-standard terms or conditions including a non-standard subscription or premium imposed on your professional indemnity/insurance?** If you answer YES please provide date and full details (If necessary please continue on a separate sheet)

☐ Yes ☐ No

7. **In the last 10 years, have you had any complaint(s) arising out of your professional practice which has not been resolved at a local level (i.e. within your own practice)?** If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

If you have answered YES to any of the above questions please provide details as requested. Use pages 10 to 11 if needed. 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.

8. **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 you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

9. **Are you aware of any incident(s) that might become a claim?** If you answer YES please provide full details of the incident(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the current status of the incident(s). (If necessary please continue on a separate sheet)

☐ Yes ☐ No

10. **Have you ever been the subject of a disciplinary inquiry or had practice privileges refused/ withdrawn/ made conditional by a health care provider?** If you answer YES please provide full details. The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the incident(s) occurred, name of indemnifier, the final outcome of the incident and was this reported to the regulatory body (If necessary please continue on a separate sheet)

☐ Yes ☐ No

11. **Have you ever been subject to any referral, complaint, inquiry, investigation or hearing by any regulatory, licensing or registration body?** If you answer YES please provide full details. The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the case. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

12. **Have you been cautioned by the police or convicted of any criminal offence? (You do not need to include spent/expired convictions, or minor road traffic offences that did <u>not</u> involve alcohol or drugs.)** If you answer YES please provide full details. The details must include: date of incident, full details of the offence, the final outcome or current position and was this reported to the regulatory body (If necessary please continue on a separate sheet)

☐ Yes ☐ No

13. **Are there any other issues of which MPS might reasonably need to be aware when considering your application for membership?** (If in doubt please indicate YES.) If you answer YES please provide all relevant information below. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

If you have answered YES to any of the above questions please provide details as requested. Use pages 10 to 11 if needed. 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.

Section C – General and/or Specialist Practice

If you are undertaking practice in both general and/or specialist practice and within an employer indemnified post, please ensure that sections C & E are both complete.

1. Please tick below to indicate your status:

- ☐ Vocational Training/Foundation Training
- ☐ General Professional Training Year 1
- ☐ General Professional/Foundation Training Year 2
- ☐ Vocational Training/Foundation Trainer (General Dental Practitioner)
- ☐ General Dental Practitioner who has previously completed vocational training/GPT in the UK or Ireland
- ☐ General Dental Practitioner who has not previously completed vocational training/GPT in the UK or Ireland
- ☐ Oral (dento-alveolar) surgery exceeding 10 hours/week on average
- ☐ Other **(Please specify):**

2. Specialist Practice

Please confirm the specialty/ies in which you practice, eg, orthodontics, if you are on the Specialist Register for each specialty, and which specialist register.

Main specialty: Are you on the specialist register? ☐ **Yes** ☐ **No**

Specialist register details:

Other specialty 1: Are you on the specialist register? ☐ **Yes** ☐ **No**

Specialist register details:

Other specialty 2: Are you on the specialist register? ☐ **Yes** ☐ **No**

Specialist register details:

If oral and maxillofacial surgeon, complete section G.

If you are claiming a concessionary rate, complete sections H and I as appropriate.

3. Are you?

- ☐ A practice owner
- ☐ Working in a practice owned by other(s)
- ☐ Employed
- ☐ Self-employed

Are you applying for membership as part of a Dental Protection Xtra practice? ☐ **Yes** ☐ **No**

If yes please provide the Dental Protection Xtra practice number and then go to section D. **If no, please go to section C4.**

Dental Protection Xtra number:

4. Do you have any other responsibilities as a practice principal? ☐ **Yes** ☐ **No**

Do you employ dental nurses or dental technicians? ☐ **Yes** ☐ **No**

If yes, how many dental nurses/dental technicians do you employ?

Would you like these nurses/dental technicians to be indemnified against negligence claims only in this way? ☐ **Yes** ☐ **No**

If yes, please provide details in Section K.

Section D – Members employed in the Keep In Touch Scheme ("KITS") - no clinical activity

Members in this category are able to receive free publications and other discounted risk management resources

1. Please indicate If you participate in the "KITS" Scheme? ☐ **Yes** ☐ **No**

Section E – Employer indemnified

Those with indemnity provided by their employer or NHS Indemnity/Crown Indemnity including those who have involvement in dentistry outside of their employer indemnified appointment (eg, private practice).

1. Please tick below to indicate your main area of practice:

☐ Community Service

☐ Dental Public Health

☐ Dental Reference Officer

☐ HM Armed Forces

☐ HM Prisons

☐ Hospital

☐ University/Dental School Staff

☐ Other **(Please specify)**

Please indicate below your current position within your area of practice eg, SHO, Senior Dental Officer etc:

Speciality:

Are you on the specialist register(s)? ☐ **Yes** ☐ **No**

If yes, please indicate which specialist register(s): (Please list all which apply)

2. Do you carry out any private work or have any involvement in dentistry outside your employer indemnified appointment?

☐ **Yes** ☐ **No**

If yes please provide details:

Also please tick below to indicate the extent of your involvement in dentistry outside your employer indemnified appointment

☐ Up to & including 5 hrs/wk (250 hrs/yr)

☐ Up to & including 10 hrs/wk (500 hrs/yr)

☐ Up to & including 20 hrs/wk (1000 hrs/yr)

☐ More than 20 hrs/wk (1000 hrs/yr)

Section F – Cosmetic and/or Oral (dento-alveolar) Surgical Procedures

1. Do you carry out any of the following?

☐ Oral (dento-alveolar) surgery ☐ Yes ☐ No

☐ Defined cosmetic procedures ☐ Yes ☐ No

If you have answered yes, please include a separate written statement on the additional page provided, detailing the extent of your involvement, and provide copies of your certificate(s) of training.

2. What percentage of your time in private practice do you spend carrying out oral (dento-alveolar) surgery or defined cosmetic procedures (excluding the neck) collectively on average per week?

☐ 25% or less

☐ More than 25%

Section G – Implant Dentistry

1. Do you carry out the placement and/or restoration of dental implants? (This does not include orthodontic anchorage implants).

☐ Yes ☐ No

Section H – Oral and Maxillofacial Surgery

1. Do you undertake any oral or maxillofacial procedures in private practice?

☐ Yes ☐ No

If yes, please indicate how many hours per week (see guidance sheet for definition):

Group 1 procedures:

Group 2 procedures:

Speciality:

Are you on the specialist register(s)? ☐ Yes ☐ No

If yes, please indicate which specialist register(s): (Please list all which apply)

If you have answered YES to any of the above questions please provide details as requested. Use pages 10 to 11 if needed. 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.

Section I – Concessionary rates Non-Clinical Practice

1. If you have no direct contact with any patients, please tick below to indicate:

- ☐ I have no clinical commitment and have up to & including 3 hours/week **(less than 150 hours per subscription year)** total involvement in dentistry and no responsibilities as a practice principal.
- ☐ I have no clinical commitment and have up to & including 10 hours/week **(less than 500 hours per subscription year)** total involvement in dentistry and no responsibilities as a practice principal.
- ☐ I have no clinical commitment but have more than 10 hours/week **(more than 500 hours per subscription year)** total involvement in dentistry, including any responsibilities as a practice principal.

2. Please describe your position:

Section J – Limited Clinical Activity

1. If you wish to apply for a reduced subscription rate because your clinical activity is limited, please tick one of the boxes below:

- ☐ Up to & including **3 hours/week** (150 hours/year)
- ☐ Up to & including **10 hours/week** (500 hours/year)
- ☐ Up to & including **15 hours/week** (750 hours/year)
- ☐ Up to & including **20 hours/week** (1,000 hours/year)
- ☐ Up to & including **25 hours/week** (1,250 hours/year)

I undertake to notify MPS promptly if my circumstances change and understand that if I fail to do so, my rights to seek assistance may be lost.

2. Please describe your position:

Section K – Employed Dental Nurses and Dental Technicians

1. **We need the full name of each dental nurse/dental technician that you employ and for whom you wish to have the right to request indemnity against clinical negligence claims only through your own membership at no extra cost.**

Please underline the surname/family name.

Name

1.

2.

3.

4.

5.

Please note: Assistance may be requested for claims against the above named nurses/technicians through your practice principal membership for clinical negligence only. With the number of complaints and GDC investigations involving dental nurses and dental technicians on the rise and the fact that 80% of all our cases are not related to clinical negligence we recommend that dental nurses and dental technicians have full individual membership.

The above named nurses/technicians can apply for full dental membership at a 50% discount, in order to provide them with personal indemnity in relation to professional matters other than negligence claims (for example, GDC complaints or investigations, inquests, criminal allegations etc). Alternatively they can be fully indemnified for free through the Dental Protection Xtra practice programme.

For more information regarding membership for dental nurses/dental technicians or the Dental Protection Xtra programme go to **dentalprotection.org** or contact Member Services helpline on **0800 561 9000**.

Please ensure that you keep us informed of the names of any nurses/technicians who start or leave your employment, take maternity leave or other career breaks etc.

Where did you learn about Dental Protection?

1. ☐ At dental school
2. ☐ Personal recommendation
3. ☐ Mailing from Dental Protection
4. ☐ Press advertising
5. ☐ GDC
6. ☐ A lecture/presentation
7. ☐ Other (please provide details)

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

1. ☐ Personal recommendation
2. ☐ Competitive subscription rates
3. ☐ MPS membership co-ordinator, please provide their initials:
4. ☐ Group arrangement
5. ☐ Dissatisfaction with previous organisation
6. ☐ Other (please provide details in the space provided)

If you have answered YES to any of the above questions please provide details as requested. Use pages 10 to 11 if needed. 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.

IMPORTANT! – Your Personal Information and Data

At times we will ask you to provide us with data and personal information including when you apply for membership, your subscription is renewed, your scope of practice changes and if you seek and we provide assistance to you. In applying for membership and by continuing as a member you agree that (i) we may hold and process your personal data including sensitive personal data (as defined in the United Kingdom's Data Protection Act 1998 (the Act)) which you provide to us or which we fairly obtain from another source for the purposes of processing your membership renewal, the administration and provision of membership services, providing you with the benefits of membership (including, but not limited to, advice, assistance and indemnity), underwriting, risk assessment, marketing, education, research and audit during your membership and for a reasonable period after your membership terminates or an application for membership renewal is rejected by us or withdrawn by you and (ii) we may share such data with third parties who may also hold and process the data for the same purposes. Under the Act you have the right to ask us for a copy of any of your personal data which we hold, for which we make a nominal charge.

You also agree that (i) we may seek information relevant to any purpose for which you have agreed we may hold personal data from other professional defence organisations, insurance companies, employers or other third parties regarding your professional practice and career history and that they may release to us such information and (ii) if you provide us with an email address or telephone number it may be used by us and third parties to contact you for any of the purposes for which you have agreed to allow us or them to hold or process your personal data.

IMPORTANT! – Please read, sign and add the current date below.

By signing and returning this form you 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, scope of practice or other details (including in relation to income and number of hours worked) change.

(vi) You have read the appropriate Information for Applicants guidance sheet

If you are submitting additional sheets or correspondence, please tick here ☐

Please check that you have completed a payment instruction form telling us how you would like to pay for your subscription and please tick here to confirm that the form is enclosed ☐

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. If you do not wish to receive such information, either via post or email, please tick here ☐

Signature _____ Date D D M M Y Y Y Y

Please note must be current date

Please remember to inform us promptly if your personal circumstances, scope of practice or other details (including in relation to income and number of hours worked).

Please attach additional pages if necessary and clearly indicate the question number for which you are providing additional information. 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.

Additional space for answers to Section B – Previous history

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

Additional space for answers to Section B – Previous history

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

Dental Protection

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2 Victoria Place
Leeds, LS11 5AE
United Kingdom.

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