**SELF-EMPLOYED LOCUM STARTER FORM**

**(Wales Locums Only)**

All new self-employed Locums working for Well must complete this form to ensure payment can be made.

A signed Locum agreement must accompany the New Starter Form.

Existing Locums must use a ‘Change of Details form’ to update their details.

**This form cannot be processed unless signed by hand and dated on Page 2.**

**PLEASE USE BLOCK CAPTIALS AND A BLACK PEN (This ensures information is legible).**

|  |  |  |
| --- | --- | --- |
| Title: | Name on GPhC Register: | GPhC Number: |
| Email Address:Mobile Phone Number: Town/City: |
| Do you have a permit to work in the UK? YES/NO Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Non UK Nationals only (Please Provide a Copy) |
| Disclosure Barring Service (DBS) **(Compulsory)**DBS Reference Number DBS Issue Date  | Own Indemnity Insurance YES/NOPolicy Number \_\_\_\_\_\_\_\_\_\_\_\_Insurers Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Graduation from UK University YES/NO |

|  |  |
| --- | --- |
| Type of Locum:Direct Agency | Name of Agency/Agencies |
| Are you registered as a Limited Company YES/NO If Yes please give details: | LTD Company name \_\_\_\_\_\_\_\_\_\_ LTD Company Number \_\_\_\_\_\_\_\_\_\_VAT Registration Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SELF-EMPLOYED LOCUM STARTER FORM (cont.)**

**(Wales Locums Only)**

|  |  |
| --- | --- |
| **Experience** | Are you employed by any other Organisation? YES/NOIf yes please provide name of organisation \_\_\_\_\_Number of hours you are contracted with org. Area you're employed:  |
| Have you previously been employed by Well? YES/NO If yes, please state job title, location and dates of employment  | Are you related to anyone who is currently employed by Well? YES/NO If yes, please give their name and location  |
| Are you familiar with Positive Solutions Pharmacy Manager? YES/NO |
| **Minimum Accreditation Required** |
| \*MUR Accreditation & \*Discharge Medicine Review(Please provide a copy) | National Enhanced ServicesAccreditation (NESA)\*(Please provide a copy if NO MUR/DMR) | Repeat Dispensing(Please provide a copy) |
| **Other Services** |
| Services | CCGs accredited to provide services in | Expiry Date |
| EHC on PGD |  |  |  |
| EHC OTC |  |  |  |
| Flu Vaccinations |  |  |  |
| Minor Ailments |  |  |  |
| Needle Exchange |  |  |  |
| Palliative Care |  |  |  |
| Smoking Cessation |  |  |  |
| Supervised Consumption(including Methadone) |  |  |  |
| Weight Management/Lipotrim |  |  |  |
| Please list below any other services you can provide and which CCGs you are accredited to deliver them in. |
| **PLEASE SIGN AND DATE THIS FORM - IT CANNOT BE PROCESSED WITHOUT A SIGNATURE AND WITHOUT ALL****PAGES BEING SENT THROUGH TOGETHER.**I certify that the information provided on this form is true and accurate.I understand that I have an obligation to inform the Professional Resourcing Team of any changes in the information I have given within 5 days of the change. |
| Signature Date  |
|  |