**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/NO  Policy 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)**

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| --- | --- | --- | --- | --- | --- | --- |
| **Experience** | Are you employed by any other Organisation? YES/NO  If 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 Services  Accreditation (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 | | | | | | | |
|  | | | | | | | |