Practice Membership Application
New Zealand

nzpractice@medicalprotection.org | medicalprotection.org/practicemembership

- **If there is insufficient space for you to complete answers fully, please complete the 'additional information section' and indicate clearly the section and question your response relates to.**
- **Where appropriate, please tick the 'yes' or 'no' box which best indicates your reply.**

Thank you for applying for practice membership with the Medical Protection Society. In this application form, 'we', 'our', 'us' and 'MPS' mean the Medical Protection Society Limited and 'you', 'your' and 'the applicant' mean the entity or entities seeking membership.
The person completing this application form on behalf of the applicant must be authorised to do so. It is important that this form is accurate and completed fully.
The information requested in this form is used by us for the purpose of considering whether or not to provide membership and, if so, on what terms. If you have any doubt as to whether any information is relevant it should be disclosed.

Date of application:

When would you like your practice membership to start?

Section A - Applicant's details

1. Full legal name of the entity or entities to be indemnified
Please provide the full name of the organisation as registered at the Companies Office

Trading since:

2. Address(es)
Address (including Post Code)

Telephone

Primary email address:

Registered office (if different to main address)

List alternative locations (if different to main address)

3. If you are a GP practice, is the practice designated as a training practice? No Yes
(if yes, please provide details)

4. Is the practice linked to another practice? No Yes
(if yes, please provide details)

5. Authorised person (primary contact)

Please provide details of the person authorised by the applicant to arrange, renew or vary the practice membership and to discuss with us any relevant details

Title: Full name:

Position: Mobile:

Telephone: Email:

Website:

Address (if different to main address)

Contact details for additional authorised person (where applicable)

Title: Full name:

Position: Mobile:

Telephone: Email:

6. Name(s) of owner(s), Director(s) who have a clinical role in the business and details of their professional experience / qualifications. If the applicant is not administered by the owner(s) / Director(s), please outline the administrative structure. In particular, state name, professional qualifications and years of experience as administrator

Name and title	Qualifications	Date qualified	Years practising	MPS membership number (if applicable)	Professional body (please specify) registration number

Section B - Doctors and other employees

1. Have any of your registered medical practitioners been suspended or removed from the relevant professional register, or had any claims or regulatory investigations in the last 10 years?

No Yes (If **yes**, we may seek further information at a later stage)

2. Please complete the table below in respect of all registered health professionals who work for the applicant, whether employed, subcontracted, locum, volunteer or other.
Please include Doctors, Nurse Practitioners, Nurses and all other Allied Health Professionals. Please use the continuation page (page 10) if needed.

Name	MPS Membership number (if already a member)	Professional status and speciality (e.g. consultant, registrar, medical officer) Nurses (enrolled, registered, triage, theater, ward etc)	Employee status *(Please select)*	Average number of weekly hours worked for the applicant

3. Please confirm the applicant checks and records indemnity / insurance arrangements annually for all regulated health professionals and that current indemnity / insurance is in place

No Yes

4. Please complete the table below detailing the staff employed or contracted within the practice
*FTE means full-time equivalent. A full-time staff member is deemed to work 40 hours per week. You may have several members working part-time whose hours, when added together, equal 1 FTE.

Role Type	Total FTE
Doctor	
Nurse Practitioner	
Nurse Prescriber	
Registered or Enrolled Nurse (please specify type)	
X-ray technicians/Radiographers	
Health care assistant	
Undergraduates or student staff	
Other medical, health or allied employees, clerical and admin employees (please specify role type)	

Section C - Indemnity / insurance history and requirements

1. Does the applicant presently hold indemnity / malpractice insurance?

No Yes - through another provider (please state provider)

2. Have you or any owner(s) or Director(s) ever had a liability indemnifier / insurer:

(a) decline a proposal or application, impose any conditions (including enhanced subscription/premium)?

No Yes (If **yes**, please provide full details below)

(b) decline to renew or had indemnity / insurance cancelled by the provider?

No Yes (If **yes**, please provide full details below)

Section D - Professional activities

1. What is the nature of your professional activities for which indemnity is required?

Please provide a full breakdown of activities e.g. ophthalmic clinic, private A&E department, GP led primary care, pharmacy services, prison / immigration healthcare and include a brief description of each. **Any services not listed will not be considered as eligible for assistance**

Please state your patient population:

Please state (where applicable) the size of your registered patient list:

Do you provide any telehealth or telemedicine services (including telephone triage)?
(If **yes**, please provide details. Please provide the reason for this and confirm that the practitioner and patient are in New Zealand. If the practitioner and or patient are not in New Zealand, please provide additional information.)

No Yes

2. Do you deliver any unscheduled care e.g. walk-in or urgent care centres?

No Yes (If **yes,** please provide full details. Please include FTE of health care professionals delivering this service e.g. nurse led facility run by 5 x nurse practitioners)

3. Please complete the following (where applicable):
(Please ensure that the total percentage adds up to 100%)

Number of beds	Total percentage of bed occupancy (approximate)

4. Do you have any medical or nursing teaching facilities?

No Yes (If yes, please provide details)

5. Within the next 12 months are there any plans to increase your size or scope? (This is to establish whether we can continue to meet your needs in accordance with our underwriting and risk criteria)

No Yes (If **yes**, please describe the plans below e.g. new corporation locations or the provision of new healthcare services)

6. Do you provide any services under a contract?
(If **yes**, please provide details below and attach a copy of your contract(s) to your application)

No Yes

7. Is there any further information that you aware of that might affect our estimate of risk or decision to grant practice membership?

No Yes

8. Can you confirm that there are documented policies and procedures in place for the following:

Formal complaints procedure No Yes

Reporting and investigating adverse incidents No Yes

Section E - Cosmetic / aesthetic

If you do not undertake any cosmetic / aesthetic activities then disregard and proceed to section F

Please confirm whether you undertake any of the following cosmetic / aesthetic procedures (per category):

First tick the left hand column and then indicate by ticking which practitioners carry out these activities on the applicant's behalf
If ticking other practitioners, please also state their job role

	Cosmetic Procedures	Medical Practitioners	Nurses	Other Practitioners	Other practitioners job role
	Category 1				
	Body contouring by injection				
	Facial thread lifting				
	Laser lipolysis with aspiration				
	Mesotherapy				
	Radio frequency assisted liposuction (RFAL)				
	Category 2				
	Chemical peels - deep				
	Dermabrasion				
	Diathermy				
	Electrosurgery				
	Hair transplantation				
	Laser lipolysis without aspiration				
	Laser therapy – ablative				
	Tattoo removal				
	Category 3				
	Chemical peels - medium				
	Depigmentation				
	Dermal fillers - semi-permanent				
	Local anaesthesia				
	Microsclerotherapy				
	Regional anaesthesia (e.g. dental block)				
	Radio frequency rejuvenation				
	Sclerotherapy				
	Skin needling - cosmetic (needle length > 1mm)				
	Category 4				
	Botulinum toxin				
	Chemical peels - superficial				
	Complexion analysis				
	Cosmeceuticals				
	Cryotherapy				
	Dermal fillers - non-permanent				
	Laser therapy - fractional				
	Laser therapy - non-ablative				
	Light therapy - LED / LHE / IPL / LLLT				
	Microdermabrasion				
	Micropigmentation				
	Skin needling - cosmetic (needle length < 1mm)				

Please provide brief details of all other cosmetic / aesthetic activities undertaken:

* Other Treatments	Medical Practitioners	Nurses	Other Practitioners	Other practitioners job role

* Please note further details may be required regarding certain procedures and practitioners qualifications

Section F - Obstetrics / Maternity

If you do not undertake any obstetric activities then please disregard and proceed to section G

1. For the last 5 years, please provide the following details:

(Please estimate current year if not a full year)	2024	2023	2022	2021	2020
Total number of deliveries					
Number of deliveries of multiple births					
Number of deliveries of stillborn infants					
Number of infants delivered at less than 32 weeks gestation					
Number of infants delivered at less than 1501 grammes					
Number of infants with Apgar score of less than 6 at 5 minutes					
Number of infants admitted to the NICU/SCBU					
Caesarean section rate					
Perinatal mortality rate					
Neonatal mortality rate					
Number of public births					
Number of private births					

2. Do you offer / provide antenatal screening (including but not limited to antenatal ultrasounds)?

No Yes

3. Do you have a policy in respect of intrapartum fetal monitoring? (If **yes**, please attach a copy of your policy to your application)

No Yes

4. Is an obstetrician available 'in-house' 24 hours a day for patients? No Yes

5. Is a second obstetrician on-call 24 hours a day who it able to attend within 30 minutes for patients? No Yes

6. Is an 'in-house' anaesthetist available solely for obstetrics 24 hours a day? No Yes

7. Is a second anaesthetist on-call 24 hours a day and able to attend within 30 minutes? No Yes

8. Can emergency caesarean sections be performed within 30 minutes 24 hours a day? No Yes

Section G - Claims and circumstances

Please answer the following questions after enquiry within the corporation and of any owner(s) / Director(s). Please provide details of any matter in which the applicant or owner(s) / Director(s) have been named or involved <u>including</u> those already reported to us. Failure to disclose full and accurate details may delay your application and / or if accepted into membership could result in the suspension or withdrawal of membership benefits and / or the termination of membership

1. During the past 10 years has any claim been made, settled or defended, or has malpractice or negligence been alleged, against the practice or any of the present of former owner(s)/Director(s). Have any circumstances been notified to indemnifiers / insurers which may result in a claim?

No Yes (If **yes**, please provide details in the box below)

2. Are there any circumstances not already notified to indemnifiers / insurers which may give rise to a claim against the practice or any prior practice or any present or former owner(s) / Director(s)?

No Yes (If **yes**, please provide details in the box below)

3. Are there any claims against previous practices which have been identified which may give rise to a claim against the practice applicant or owner(s) / Director(s)?

No Yes (If yes, please provide details in the box below)

4. Have the owner(s), Director(s) or staff member been subject to professional disciplinary or regulatory proceedings or criminal prosecution?

No Yes (If yes, please provide details in the box below)

5. Record keeping

Do you maintain accurate descriptive records of all medical services and equipment used in procedures? No Yes

If you are responsible for storing and disposing of medical records, do you ensure this is done in line with official guidance on managing records, including the retention schedules published by the relevant professional bodies? No Yes

Do you maintain a record of all requests on behalf of patients for medical records? No Yes

Will all medical records be made available for inspection and use, without charge, by us or our appointed representatives together with any oral or written information, assistance, signed statements, evidence or depositions as required in the investigation or defence of any claim? No Yes

If **no** to any of the above, please provide details below

6. Is there any further information that you are aware of that might affect our estimate of risk or decision to grant practice membership?

No Yes (If **yes**, please provide details below)

IMPORTANT! Please read the following information

Please note – This application should be approved and submitted by a duly authorised representative and dated. Any delay in returning after signing may invalidate this application. If all applicable sections are not completed fully, this will delay the processing of your application

Signed:

Print name:

Position:

For and behalf of:

By applying for MPS membership:
You confirm you understand that membership of MPS is subject to:
(i) approval and is not conferred automatically
(ii) payment of the appropriate subscription
(iii) MPS's Memorandum and Articles of Association, as amended from time to time, and that all benefits are granted at the discretion of MPS's Council.

You confirm that you are, and will remain, duly licenced in accordance with the law to practice at the address(es) specified in Section A of this form.

You confirm that all staff are fully trained and competent for the work they undertake and properly supervised.

You acknowledge that MPS is not an insurance company and that the benefits of membership are discretionary.

You warrant that all information provided to MPS:
(i) is true, accurate and complete in all respects
(ii) has been collated and sent by a properly authorised person.

You must notify us as soon as practicable if you believe any information given to be incorrect or if there are any events, changes or proposed changes which may cause the information we hold to be inaccurate or out of date.

You acknowledge that any failure to disclose full and accurate details and / or delay or failure to provide updated or additional information may delay the application and / or if you are accepted into membership could result in the suspension or withdrawal of membership benefits and / or the cancellation and / or termination of membership.

Data Protection Information

To find out more about how we collect, use and handle your data including Special Category Data, please see the Privacy Statement on our website medicalprotection.org/.

Please tick the following box to confirm that you have read the above declaration (and any accompanying guidance)

Please do not return the application form until all sections have been completed in full, where applicable

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The Medical Protection Society Limited (MPS) is a company limited by guarantee registered in England with company number 36142 at Level 19, The Shard, 32 London Bridge Street, London SE1 9SG. MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association. MPS® and Medical Protection® are registered trademarks.

Additional information

Please use this section if there is insufficient space for you to complete answers fully within this application form. Please indicate clearly the relevant section and question if you are adding any additional text here