**Application for Designated Medical Practitioner and Second Opinion Work**

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| --- | --- | --- | --- | --- |
| **Name:** |  | | | |
| **GMC No:** |  | | | |
| **Home Address:**  *Please tick if this is your preferred choice for contact* **🞎** |  | | | |
| **Work Address:**  *Please tick if this is your preferred choice for contact* **🞎** |  | | | |
| **Email Address:**  *Please tick if this is your preferred choice for contact* **🞎** |  | | | |
| **Secure Email Address:**  *Preferred choice for contact?* **🞎** |  | | | |
| **Work Tel No:**  *Preferred choice for contact?* **🞎** |  | | | |
| **Home Tel No:**  *Preferred choice for contact?* **🞎** |  | | | |
| **Mobile No:**  *Preferred choice for contact?* **🞎** |  | | | |
| **Secretary’s Name:** |  | | | |
| **Secretary’s Email Address:** |  | | | |
| Please tick appropriate box to specify which areas of psychiatry you would be willing to undertake as a DMP/Second Opinion Doctor: | | | | |
| General Adult Psychiatry | | **🞎** | | |
| CAMHS | | **🞎** | | |
| CAMHS with LD | | **🞎** | | |
| CAMHS who need ECT | | **🞎** | | |
| Forensic | | **🞎** | | |
| Learning Disability | | **🞎** | | |
| Old Age | | **🞎** | | |
| Artificial Nutrition - general (for psychiatric conditions except eating disorder) | | **🞎** | | |
| Artificial Nutrition- specialist (for patients with eating disorders) | | | **🞎** | |
| Please give details of artificial nutrition experience (if applicable): | | |  | |
| ECT (specialist) | | | **🞎** | |
| Please give details of ECT experience (if applicable): | | |  | |
| Are you willing to undertake visits under the Adults with Incapacity (AWI) Act?  **YES/NO**  *(Training will be provided at DMP induction for MHA work and AWI work. The comprehensive DMP handbook will act as a reminder. The MWC medics will be available for support.)* | | | | |
| My Psychiatric Speciality is: | | |  | |
| My areas of expertise/special interest/ other skills e.g. able to communicate in other languages: | | |  | |
| Would you be available to undertake visits during office hours (e.g. to go to a Resource Centre between 9 am and 5 pm)? **YES/NO** | | | | |
| I confirm that I am registered with a Peer Group for CPD: **YES/ NO** | | | | |
| I have RCPsych CPD certificates of good standing yearly (at least 50 hours of peer group-approved CPD per year): **YES/ NO**  If no, please state the equivalent that you have: | | | | |
| Do you currently have full GMC registration with a licence to practice? **YES/ NO** | | | | |
| What is your date for your next GMC revalidation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| When was your last revalidation date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| When was your last appraisal date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did you have yearly appraisals? **YES/ NO**  If not, did you have 4 appraisals in the last 5 years? **YES/ NO** | | | | |
| Who is your Responsible Officer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Which is your Designated Body? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| I confirm that I am a section 22 Approved Medical Practitioner (AMP) with at least 3 years’ experience using the Mental Health (Care and Treatment) (Scotland) Act 2003: **YES /NO** | | | | |
| For your AMP status, which Heath Board are you registered with? | | | | |
| I possess MRCPsych or an equivalent qualification: **YES/NO**  Please state the equivalent if not MRCPsych: | | | | |
| I am currently in permanent NHS employment: **YES/NO** | | | | |
| If no, please state the position, date and place of last NHS employment: | | | | |
| I am currently in locum NHS employment: **YES/NO** | | | | |
| Current grade and years of experience in this grade: | | | | |
| Date of retirement or pending retirement (if applicable): | | | | |
| Health Board Areas I would be prepared to travel to for DMP work (please tick): | | | | |
| All Health Boards | | | | **🞎** |
| Ayrshire and Arran | | | | **🞎** |
| Borders | | | | **🞎** |
| Dumfries and Galloway | | | | **🞎** |
| Fife | | | | **🞎** |
| Forth Valley | | | | **🞎** |
| Grampian | | | | **🞎** |
| Greater Glasgow and Clyde | | | | **🞎** |
| Highland | | | | **🞎** |
| Lanarkshire | | | | **🞎** |
| Lothian | | | | **🞎** |
| State Hospital | | | | **🞎** |
| Tayside | | | | **🞎** |
| Western Isles | | | | **🞎** |
| Orkney | | | | **🞎** |
| Shetland | | | | **🞎** |
| I would consider doing occasional visits to Grampian, Highlands, Orkney,  Shetland and Western Isles: **YES/NO**  (Saying yes does not commit you to this). | | | | |
| Do you have a Disclosure Scotland Protecting Vulnerable Groups (PVG) certificate for adults? **YES/NO** | | | | |
| If you plan to do DMP assessments for children in future after a successful application, do you have a Disclosure Scotland Protecting Vulnerable Groups (PVG) certificate for children?  **YES/NO/Not planning to do DMP assessments for children** | | | | |

Please return this form to [dichelle.wong@nhs.scot](mailto:dichelle.wong@nhs.scot) with the following:

1. A brief CV including your GMC number and the names and email addresses of two professional referees. One referee should be a medical manager or medical director who can confirm you are in good standing and have participated in the appraisal process. The other referee should be a Consultant who can comment on your skills to be a Designated Medical Practitioner/ second opinion doctor
2. RCPsych CPD certificate of good standing or equivalent
3. Completed indemnity form (see other file in the application pack please)