**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 your current 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 Psychiatrist 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)