

Part 1 to be completed by the APPLICANT. Please write clearly in BLACK INK

Doctor' name:			
Name of surgery:			
Address of surgery:			
		Postcode:	

Health and Social Care Act 2008

Name of service provider:			
Regulated activity(ies) to be provided or managed:			
Address of service provider or location:			
		Postcode:	

I have applied to the Care Quality Commission to be registered to **run/ manage/ supervise the management of** (delete as appropriate) the **healthcare service/ social care service** (delete as appropriate) as named above.

To enable the Care Quality Commission to assess my fitness, I am required to obtain a medical report about my physical and mental health. This must include any past, present or long-term disability that may affect my application. Please provide the report using this form.

I understand that I will be responsible for paying any fee you may charge me. Please note that the Care Quality Commission may contact you to discuss anything in the report or to obtain further clarification on the information provided.

Note: this medical report is only valid for three months from the date of receipt.

Yours sincerely,

Signature of applicant:

Please note that all fields within this form are mandatory. Incomplete forms will NOT be processed.

Name of applicant:			
Home address:			
		Postcode:	
Home telephone:			
Work telephone:			
Mobile:			
Email:			

Part 2 to be completed by the DOCTOR. Please write clearly in BLACK INK

Medical report for (patient's name):			
Address:			
		Postcode:	

Please answer the following questions and include or attach any supporting information that you consider to be relevant.

1. How long have you known the person named above?			
	Years		Months

2. Is there anything in the person's medical history that would make them unfit to run, manage or supervise a health service or social care service?	
Yes <input type="checkbox"/> No <input type="checkbox"/> If you answered yes, please provide details.	

3. Is this person currently receiving treatment or do they have any conditions that will require frequent or long periods of absence, or would otherwise affect their ability to carry out their role?

Yes No If you answered yes, please provide details.

Doctor's name (print):	
Post held:	
Telephone:	
Signature:	
Date:	
Official stamp:	

Data Protection Act 1998 statement

The information provided in this form and any supporting documentation submitted will be used by the Care Quality Commission to process the related application for registration. Please note that this may include fact verification.

The information within this application will only be handled by those who are authorised to receive it in the course of their duties. It will be stored securely and may be kept electronically in accordance with the Care Quality Commission's information governance policies (see www.cqc.org.uk). Once we have made a decision on registration, the information will be saved in accordance with our retention and disposal schedule.

I agree to my information being used as stated.

Doctor's signature:	
Print name:	
Date:	

Thank you for providing this information.

Please return this form directly to the Care Quality Commission at the address below:

**CQC HSCA Registrations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA**