Annex 7

Acknowledgement of Request to Incorporate and Medical Incorporation Assessment Template

[*date*]

Dear [*name*]

Contract No [insert contract number]

Request to become a [company limited by shares / qualifying body / other]

Thank you for your letter dated [*insert date*], informing us of your request to incorporate. Incorporation is not considered to be a minor contractual change, so further enquiries and consideration needs to take place.

In order for us to consider your request, we ask that you complete the enclosed template and return it to us at the above address.

In addition to the template we also request that you provide copies of the documentation listed below to support the request.

We appreciate that all the documentation will not be available at the time of your request as you may only apply to Companies House and the Care Quality Commission if we agree to your request for incorporation in principle.

Those marked with \* should be forwarded as soon as these become available as the contract documentation cannot be produced until these are received:

\* Companies House Certificate detailing all Directors

Copy of passport for all Directors

Professional indemnity

Employers liability

Public liability

\* Copy of written confirmation from the CQC that they do not intend to impose any restrictions on registration as the incorporated company

Yours sincerely

*[name]*

*[title]*

Enc.

Medical Incorporation Assessment Template

All contractors/partnerships wishing to incorporate must complete the details requested below.

Please note ALL questions must be answered in full. If a question is not applicable please write N/A in the box provided.

# Details of the Applicant

## Please provide the name and other required contact details of the applicant (person for contact purposes with this application).

|  |  |
| --- | --- |
| Applicant Name: |  |
| Address: |  |
| Telephone: |  |
| Fax: |  |
| E-mail: |  |

## Current status of organisation – please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Individual medical contractor(s) |  |  | Partnership |  |

## Current contract type – please mark ‘x’ in the appropriate box:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| GMS |  |  | PMS |  |  | APMS+ |  |

Please state the nature of the incorporation – please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Company limited by shares |  |  | Qualifying Body |  |

## Where the proposed contractor is a company limited by shares, please provide a complete breakdown of share ownership.

|  |  |
| --- | --- |
| Shareholder:  Percentage of shares held: |  |
| Shareholder:  Percentage of shares held: |  |

## Please provide details of the proposed contractor

|  |  |  |
| --- | --- | --- |
| Name of Proposed Contractor: |  | |
| Trading Name: |  | |
| Previous Trading Name (if different) |  | |
| Registered Address: |  | |
| Total Number of proposed Directors: |  | |
| CQC registration |  | |
| Details of proposed Directors, including full name: | Name (please print) | |
| (1) | |
| (2) | |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| Proposed date of incorporation: |  |  |

1. Impact on Contract

## Will the process of incorporation have any effect on current patient services – please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  |  | No |  |

## Will the process of incorporation have any effect on the location of current service provision – please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  |  | No |  |

## Will the process of incorporation have any effect on the current range of services provided – please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  |  | No |  |

## Will there be any change to the practitioners providing the service – please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  |  | No |  |

## If any of these questions receives a YES response, please provide details of the effect:

|  |  |
| --- | --- |
| Details**:** |  |

1. Legal and Regulatory Status

## Please confirm you have or will have (for the proposed new entity) all relevant insurance and indemnity requirements in place prior to contract signature – please mark ‘x’ in the appropriate box:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Insurance category: | Name of insurance company | Policy no. | Expiry Date | Amount of cover (£) | Name of staff member |
| Professional indemnity |  |  |  |  |  |
| Employers liability |  |  |  |  | N/A |
| Public liability |  |  |  |  | N/A |

## If you are proposing to incorporate as a qualifying body, please confirm the requirements of the NHS Act 2006 are satisfied in relation to that qualifying body: Please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  |  | No |  |

## Have any of the proposed directors been convicted of any of the following offences:

* Conspiracy
* Corruption
* Bribery
* Fraud
* Money laundering
* Any other offences

Please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  |  | No |  |

If Yes, please provide details in the box below:

|  |  |
| --- | --- |
| Details: |  |

## Legal and regulatory status details - Please provide details of any criminal conduct of any director, officer or senior employee of the current or proposed organisation resulting in conviction or in respect of which a prosecution or investigation is pending or in progress. If none, please state ‘None’.

|  |  |
| --- | --- |
| Details: |  |

## Please state whether any medical practitioners employed by the current or proposed organisation have, during the last three years, had their professional registration removed or suspended or whether they are currently under investigation, and provide relevant details. If none, please state ‘None’.

|  |  |
| --- | --- |
| Details: |  |

# Practice Profile and Performance

## Current opening times

|  |  |  |
| --- | --- | --- |
| Day | AM | PM |
| Monday |  |  |
| Tuesday |  |  |
| Wednesday |  |  |
| Thursday |  |  |
| Friday |  |  |
| Saturday |  |  |
| Sunday |  |  |

## Is the practice currently accepting new patients? Please mark ‘x’ in the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  |  | No |  |

If NO, please confirm the reasons below.

|  |  |
| --- | --- |
| Details: |  |

## Please provide details of any complaints received by the practice relating to the provision of service and actions taken as a result of the complaint. If none, please state ‘None’.

|  |  |
| --- | --- |
| Details: |  |

## Please provide details of how you will maintain/improve access for existing and new patients.

|  |  |
| --- | --- |
| Details: |  |

## Please provide details of any other benefits to patients should the Commissioner approve your application for a contract. If none, please state 'None'.

|  |  |
| --- | --- |
| Details: |  |