Annex 9

Acknowledgement of Request to Dis-incorporate and Medical Dis-incorporation Assessment Template

[*date*]

Dear [*name*]

Contract No [insert contract number]

Request to dis-incorporate to [an individual / a partnership]

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

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

Yours sincerely

*[name]*

*[title]*

Enc.

Medical Dis-Incorporation Assessment Template

All contractors wishing to revert to an individual or partnership contract 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: |  |
| Email: |  |

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

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

## Current Contract Type – Please mark ‘x’ in the appropriate box:

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

##

## Please state the nature of the reversion requested – Please mark ‘x’ in the appropriate box:

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

## Where the applicant is proposing to form either a single handed or partnership, please supply the following information:

|  |  |
| --- | --- |
| Partnership Name / Trading Name [delete as applicable]: |  |
| Current Trading Name: |  |
| Previous Trading Name (if different): |  |
| Address and telephone details if different to 1.1: |  |
| CQC registration: |  |
| Total Number of members: |  |
| Member details: |  |
| Proposed date of commencement: |  |

# Impact on Contract

## Would the change if approved have any effect on current patient services – please mark ‘x’ in the appropriate box:

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

## Would the change if approved have any effect on the location of current service provision – please mark ‘x’ in the appropriate box:

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

## Would the change if approved have any effect on the current range of services provided – please mark ‘x’ in the appropriate box:

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

## Will there be any change in 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: |  |

# Legal and Regulatory Status

## Please confirm that 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 |

## Please confirm that the eligibility criteria set out in the NHS (General Medical Services Contracts) Regulation 2004 OR the NHS (Personal Medical Services Agreements) Regulations 2004 (whichever is relevant) is met. Please mark ‘x’ in the appropriate box:

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

## Have any of the proposed 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 for anyone proposed 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 state 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 we approve your application for a single handed or partnership contract. If none, please state 'None'.

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

## Please provide further details on any future intentions with regards the application. If none, please state 'None'.

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