MEMBERSHIP SCHEME OF CO-OPERATION NZCCP

04 801 6088 | office@nzccp.co.nz

Medical Protection

Please complete all parts of this form in **BLACK INK** and **BLOCK CAPITALS** and return to: Caroline Greig, NZCCP, PO Box 24088, Wellington 6142. For enquiries please telephone: 04 801 6088 or email: office@nzccp.co.nz. If your application for membership of MPS is approved, it will be dated from the day following receipt of your application unless you specify a later start date in the box to the right.

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Section A – Personal details

Surname

First name(s)

Title

Maiden/previous name if any

Date of birth (DD/MM/YYYY)

Gender ☐ Male ☐ Female

Nationality

Country of Practice

Country of permanent residence

Address of correspondence

Postcode (zip or postal area)

Daytime telephone

Evening Telephone

Mobile number

Fax number

Email address

Degrees and diplomas

Medical school

Month and year of graduation (MM/YY)

Annual Practicing Certificate registration number and date of registration (DD/MM/YY) – your application may be delayed if this is not provided

Specialist registration number

Date of specialist registration (DD/MM/YY)

Are you an NZCCP member? ☐ Yes ☐ No

IMPORTANT! – Please read the following

1. As part of our normal process, we may approach your previous indemnity or insurance organisation for your claims history. This process will take a minimum of 15 working days.
2. Failure to disclose full and accurate details about your previous history, practice and income may invalidate your membership which means you are not entitled to any advice or assistance from MPS.
3. When completing the previous history section on pages 2 and 3 you must account for any gaps in your indemnity or insurance history during the last 10 years and also any break in clinical practice during the previous 2 years.
4. We will not assist with any matter arising from an incident pre-dating your MPS membership.
5. If you are leaving a claims made insurance contract, please ensure you have notified your previous provider of any adverse incident of which you are aware, that could become a claim. You should also check with the provider whether any closing payment is required to secure "run-off" cover for any future claim which may arise from an incident pre-dating your MPS membership.

Please note that signing the declaration on page 5 indicates acceptance of the following requirements:
Members undertake to keep MPS informed of their current address and any changes in their professional circumstances. Failure to notify us of any change of address or scope of practice could result in the suspension or the withdrawal of the benefits of membership and/or the withdrawal and/or the termination of your membership. MPS is not an insurance company. The benefits of MPS membership are granted at the discretion of Council and are subject to the terms and conditions of the MPS Memorandum and Articles of Association, as amended from time to time.

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Section B – Previous History ! PLEASE READ THE IMPORTANT INFORMATION BELOW

In this section you must include details of any matter in which you have been named or involved. Please include any pending, unresolved or closed issues, even those already reported to MPS. Failure to disclose full and accurate details about your previous history may delay your application. If necessary please continue your answers on a separate sheet.

1. **Have you had any professional indemnity/insurance before?** ☐ **Yes** (Please go to Q2) ☐ **No** (Please go to Q3)

2. **Please give the name of all other organisations and the dates during the last 10 years which you were a member or policyholder. If you were previously a member of MPS, please give your membership number and your full name at the time** (if it has changed).

Organisation	From DD/MM/YYYY	To DD/MM/YYYY	MPS number	Full Name	Other membership or policy number

3. **Have you at any stage practiced without professional indemnity during the last 10 years (ie, Please exclude any period(s) protected by state, employer, insurer or MDO indemnity)?** (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reasons below.

☐ Yes ☐ No

4. **Have there been any breaks in your clinical practice of more than 6 months in the last 2 years?** (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reason for any gap. Please also provide details of any continuous professional development or refresher training that has been undertaken.

☐ Yes ☐ No

5. **Have you ever previously been refused professional indemnity/insurance including a decline to renew or had it withdrawn/ voided?** (If in doubt please indicate YES.) If you answer YES please provide a summary in your own words providing dates and reasons, including copies of any correspondence.

☐ Yes ☐ No

6. **Have you had any non-standard terms or conditions including a non-standard subscription or premium imposed on your professional indemnity/insurance?** If you answer YES please provide date and full details. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

7. **In the last 10 years, have you had any complaint(s) arising out of your professional practice which has not been resolved at a local level (ie, within your own practice)?** If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

If you have answered YES to any of the above questions please provide details as requested. Use the enclosed pages if needed and include additional pages if required. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

8. **In the last 10 years have you been involved in any claim(s) for compensation or damages arising out of your professional practice regardless of the outcome?** If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

9. **Are you aware of any incident(s) that might become a claim?** If you answer YES please provide full details of the incident(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the current status of the incident(s). (If necessary please continue on a separate sheet)

☐ Yes ☐ No

10. **Have you ever been the subject of a disciplinary inquiry or had practice privileges refused/ withdrawn/ made conditional by a health care provider?** If you answer YES please provide full details. The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the incident(s) occurred, name of indemnifier, the final outcome of the incident and was this reported to the regulatory body. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

11. **Have you ever been subject to any referral, complaint, inquiry, investigation or hearing by any regulatory, licensing or registration body?** If you answer YES please provide full details. The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the case. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

12. **Have you been cautioned by the police or convicted of any criminal offence? (You do not need to include spent/expired convictions, or minor road traffic offences that did NOT involve alcohol or drugs.)** If you answer YES please provide full details. The details must include: date of incident, full details of the offence, the final outcome or current position and was this reported to the regulatory body. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

13. **Are there any other issues of which MPS might reasonably need to be aware when considering your application for membership?** (If in doubt please indicate YES.) If you answer YES please provide all relevant information below. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

If you have answered YES to any of the above questions please provide details as requested. Use the enclosed pages if needed and include additional pages if required. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

Section C – Practice details

If you are registered to practise in any other Country please state which:

Will all your professional practice be carried out in the Country in which you are applying for membership?

☐ Yes ☐ No If **No**, please provide Country and full details (If necessary please continue on a separate sheet)

Will you be involved in treating or providing advice to patients outside of the Country in which you are applying for membership? (eg, telemedicine)

☐ Yes ☐ No If **Yes**, please provide Country and full details (If necessary please continue on a separate sheet)

Primary location of practice

- ☐ Child & Family
- ☐ Forensic
- ☐ ACC Sensitive Claims
- ☐ Intellectual Disability
- ☐ Alcohol & Drug
- ☐ Neuropsychology
- ☐ DHB
- ☐ Corrections
- ☐ University
- ☐ Private Practice
- ☐ PHO
- ☐ Other (Please specify)

IMPORTANT! – Please read the following and sign below

Please note: We require you to tell us about any current claims, complaints (not resolved at local level), previous criminal convictions, disciplinary or similar issues which have not been previously notified to MPS.

PLEASE PROVIDE A COPY OF YOUR ANNUAL PRACTISING CERTIFICATE (APC)

IMPORTANT! – Your Personal Information and Data

When interacting with MPS, you may choose to give MPS information about your criminal convictions and off ences (including alleged off ences), your health, race, ethnic origin, sex life, sexual orientation and trade union membership ("Special Category Data"). This happens where that information is relevant to your membership or the actual or potential provision of advice, assistance or indemnity. We may also receive Special Category Data about you from others in connection with membership or advice, assistance or indemnity (e.g. from a complainant, claimant, witness, expert, court or regulator).

To find out more about how we collect, use and handle your data including Special Category Data, please see the Privacy Statement on our website **medicalprotection.org**

When you tick the box below, you expressly consent to MPS processing your Special Category Data for the purposes of providing you with membership and its benefits (including assistance and indemnity).

☐ **I consent**

You may withdraw consent to such processing by contacting MPS, but if you do so we will no longer be able to provide you with membership and its benefi ts.

IMPORTANT! – Please read, sign and add the current date below.

By signing and returning this form, you agree and confirm that:

(i.) You wish to apply for membership of MPS subject to the Memorandum and Articles of Association

(ii.) You understand that any failure to disclose full and accurate details may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership

(iii.) You understand that membership is not conferred automatically and is subject to approval by MPS

(iv.) You acknowledge that any subscription payments made are subject to verification and that acceptance of a payment by MPS does not of itself confirm membership and/or entitlement to request benefits

(v.) You will inform us if your personal circumstances or scope of practice change

(vi.) We may seek information from other professional defence organisations, insurance companies, employers, and/or other third parties in respect of membership and that they may release to us such information

(vii.) For the purposes of New Zealand law and the New Zealand Privacy Act 1993, we may obtain, process, retain and transfer your personal data as set out in the Privacy Statement on our website **medicalprotection.org/**

Date D D M M Y Y Y Y **Please note must be current date**

☐ If you are submitting additional sheets or correspondence, please tick here

☐ Please check that you have completed a payment instruction form telling us how you would like to pay for your subscription and please tick here to confirm that the form is enclosed

☐ In order to provide you with the best possible service we would like to inform you of other products and services offered by us that we believe may be of interest to you. To opt-in to receive such information, either via post or email, please tick here.

You can update your marketing preferences by contacting us.

Medical Protection – New Zealand contact information
c/o The New Zealand College of Clinical Psycologists
PO Box 24088, Wellington 6142

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Method of payment

Step 1: Check what your MPS subscription rate should be, using the current MPS subscription rates as enclosed.

Step 2: Indicate the payment method and amount of your subscription below.

Step 3: Write your cheque.

Step 4: Sign, date and return this payment instruction with your application form to:
Caroline Greig, NZCCP, PO Box 24088, Wellington 6142.

☐ Cheque (in full) – made payable to NZCCP NZ$

Signature: Date: (DD/MM/YYYY)

Please note: It is your responsibility to provide accurate information about your professional practice and relevant income (which may affect the subscription you pay). Failure to notify us of any change of address, private practice income and scope of practice could result in the suspension of the benefits of membership and/or the termination of your membership.

By completing this form I understand that if my subscription or any other liability to MPS is in arrears for more than one month, then I shall cease to be entitiled to any membership benefit from MPS from that date when such subscription or liability fell due. I also understand that after non-payment for two months MPS may terminate my membership by notice. although my liability to MPS alreaddy accrued will not ne affected.

I wish to pay my subscription (including 15% GST) in accourdance with the indicated payment method above.

Signature: Date: (DD/MM/YYYY))

Please tell us why you have chosen MPS – Your comments are important to us, please tick below

1. ☐ Personal recommendation
2. ☐ Competitive subscription rates
3. ☐ MPS membership co-ordinator, please provide their initials:
4. ☐ Group arrangement
5. ☐ Dissatisfaction with previous organisation
6. ☐ Other (please provide details in the space provided)

Medical Protection – New Zealand contact information
c/o The New Zealand College of Clinical Psycologists
PO Box 24088, Wellington 6142

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Additional space for answers to Sections

Please clearly indicate the question number that you are providing details for below.

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Additional space for answers to Sections

Please clearly indicate the question number that you are providing details for below.

Please attach additional pages if necessary and clearly indicate the question number for which you are providing additional information. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.