

Practice Membership application form

South Africa and/or Namibia

rsaenquiries@medicalprotection.org | rsaenquiries@dentalprotection.org

Medical
Protection



Dental
Protection



Please complete all editable sections of this form electronically and return by email to the relevant address above

Section 1: Application information

Practice details

Practice name

Practice address

Postal code

Is the practice based on more than one site?

☐ Yes

☐ No

If **Yes**, please provide additional details and continue in Section 3, if required.

Country of operation

☐ South Africa

☐ Namibia

☐ Both

Legal structure (for example, sole proprietor, incorporated, partnership, company)

Trading since (DD/MM/YYYY)

Registration number(s) (if applicable)

Proposed Practice Membership start (DD/MM/YYYY)

Practice profile

Type

☐ Medical

☐ Dental

☐ Mixed

What is the nature of your professional/clinical activities for which indemnity is required? Please provide a breakdown of all activities offered by the practice (for example, GP led primary care, specialist practice):

Contact details (authorised persons)

Please list all individuals authorised by the practice owner(s) to arrange, amend or renew the Practice Membership, and to discuss relevant details with Medical/Dental Protection:

(Primary contact) Full name

Date of birth

Position in the practice

Telephone

Email

Address (if different)

(Additional contact) Full name		Date of birth	
Position in the practice			
Telephone			
Email			
Address (if different)			
Practitioner composition and eligibility			
Total number of practitioners working at the practice:			
Practitioner count by employment status:			
• Owners/Directors/Partners		• Employed practitioners	
• Locums/Contractors		• Volunteers	
• Other			
Number of practitioners with individual indemnity through Medical/Dental Protection			
Number of practitioners indemnified/insured elsewhere			
Please provide the following information for each practitioner that is not indemnified by Medical/Dental Protection (attach additional sheets if needed):			
• Role/Professional designation			
• Employment status (owner/employed/locum/contractor)			
• Individual indemnity provider/ insurer name			
Claims or circumstances (practice-level)			
Has the practice been named in any claims (past 10 years)?		☐ Yes	☐ No
Any known circumstances that may give rise to a claim (past 10 years)?		☐ Yes	☐ No
If Yes , please provide details of:			
• Nature of claim • Date of incident • Outcome/status • Financial exposure (if known)			
Any failure to disclose full and accurate details may delay your application or if accepted, could result in us rejecting requests for assistance, declining or withdrawal of membership benefits and/or the cancellation or non-renewal of your Practice Membership.			
Previous indemnity/insurance			
• Present provider (if applicable)			
• Previous provider(s) and policy periods (if any)			
• Any refused/declined indemnity/insurance, cancellations or special terms imposed?		☐ Yes	☐ No
If Yes , please provide full details and continue in Section 3, if required.			
• Current renewal date (if applicable)			

Retroactive protection can be added to Practice Membership. Would you like to add retroactive protection to this membership?		☐ Yes	☐ No
If Yes* , please provide your retroactive date (DD/MM/YYYY)			
*Because a retroactive date extends the practice's reporting rights for past work previously covered under another arrangement, it is crucial that the retroactive date specified for your Practice Membership is accurate.			
Please confirm you understand assistance will not be granted for claims or circumstances: • That occurred during the retroactive period which have or should have been notified to a previous provider; or • Where the treating healthcare practitioner did not hold their own valid individual Medical/Dental Protection membership (or protection elsewhere) at the date of the incident; or • Where the practice operated without any indemnity or insurance arrangements in place. ☐ Yes, I understand assistance will not be granted for claims or circumstances.			

Practice protocols

Please confirm whether the practice has:

• Formal patient referral protocols	☐ Yes	☐ No
• Test results tracking and follow-up systems	☐ Yes	☐ No
• Incident reporting and investigation system	☐ Yes	☐ No
• Complaints handling procedure	☐ Yes	☐ No
• Patient safety escalation process	☐ Yes	☐ No

If you are unable to confirm any of the above statements, please provide an explanation why (continue in Section 3, if required).

Section 2: Declaration and eligibility confirmation

Practice governance, compliance and eligibility confirmation

Please confirm that:

- You are, and will remain duly licensed, in accordance with the law to practice at the address specified in Section 1 of this application form.
- All registered health practitioners working in the practice have appropriate indemnity or insurance in place throughout the time they work for the practice, either with Medical/Dental Protection or elsewhere, covering their full scope of practice in South Africa and/or Namibia and they comply fully with the terms of their protection.
- You maintain accurate descriptive records of all clinical services, procedures, and equipment used, including a log of all patient requests for access to their medical/dental records.
- You store and dispose of medical/dental records in line with official guidance on managing records, including the retention schedule published by the relevant professional bodies.
- All medical/dental records will be made available for inspection and use, without charge, by us or our appointed representatives together with any oral or written information, assistance, signed statements, evidence or depositions as required in the investigation or defence of any case or claim.
- You maintain a record of the indemnity or insurance arrangements of all registered health practitioners working in the practice and provide Medical/ Dental Protection with such evidence, if requested.
- All registered health practitioners working in the practice maintain full registration with the Health Professions Council of South Africa (HPCSA) and Health Professions Council of Namibia (HPCNA) or appropriate regulatory body, and this is reviewed by the practice at least annually.
- All registered health practitioners work within the boundaries of their professional competence, scope of practice and remit of their employee contract/agreement.
- Retain a record of the contact details for all registered health practitioners which should be updated at the time they cease to work for the practice, and there will be full co-operation in tracing treating clinicians, if required.
- All staff are fully trained and competent for the work they undertake and properly supervised.

☐ Yes, I confirm.

If you are unable to confirm any of the above statements, please provide an explanation why (continue in Section 3, if required).

Important – Data Protection information

To find out more about how we collect, use and handle your data including special category data, please see our Privacy Notice on the website medicalprotection.org/privacy or dentalprotection.org/privacy

Please tick the following box to confirm that you have read the above Privacy Notice. ☐

Declaration and signatures

I/We confirm that all information provided is true, accurate, and complete to the best of my/our knowledge and belief. I/We understand that this information will be relied upon by Medical/Dental Protection in assessing risk and deciding whether to continue Practice Membership and confirm that no material facts have been mis-stated or omitted.

Full name	Signature
Position in the practice	Date (DD/MM/YYYY)
Full name	Signature
Position in the practice	Date (DD/MM/YYYY)
Full name	Signature
Position in the practice	Date (DD/MM/YYYY)
For and on behalf of (practice name)	

If your application is approved, membership for the coming term will commence from your proposed start/retroactive date.

Medical Protection | Dental Protection

Victoria House, 2 Victoria Place, Leeds, LS11 5AE, United Kingdom

Please return the completed form by email to rsaenquiries@medicalprotection.org | rsaenquiries@dentalprotection.org

medicalprotection.org | dentalprotection.org

Section 3: Supplementary information

Please use this box to record the answers to any questions for which you require additional space, noting the appropriate section and question number.