Agenda Item 6

Enclosure 4

Paper RC 11 / 02

REGISTRATION COMMITTEE

CHIROPODISTS GRANDFATHERING FORM

From : Secretary to the Committee

hpc health professions council

Health Professions Council

Park House • 184 Kennington Park Road • London SE11 4BU

Application for registration under section 13 (2) of Orders in Council - Grandfathering

All applicants who wish to be considered for state registration under the Grandfathering route must complete all sections of this form.
Failure to do so will result in delays in processing and will affect your registration.
The opportunity to make an application will only exist from.....
No applications will be accepted after this date.

Personal Information

Please use block capitals only throughout this application form. In addition the use of black ink, if given would facilitate copying.

Surname or family name - Mr/Ms/Miss/Mrs/Dr/Prof (Delete as appropriate) .....

Forename(s) or first name(s) .....

Date of birth .....

Evidence of name change - *tick if sent* ◯
A copy of your marriage certificate or other evidence of change of name must be sent for inspection

Nationality ..... Sex *Male* ◯ *Female* ◯

Profession with which you want to register .....

Registered address .....

This should be any address at which you are able to receive any communication sent to you by HPC. HPC is not responsible for delays if you move and do not inform us in writing. ..... Postcode .....

Qualification(s) .....

Please enter here the basic professional qualification held - eg. BSc etc and date awarded - together with any further (higher) qualifications within the profession. Unless you indicate otherwise only the qualifications entered here will be considered for your state registration. .....

AA .....

FOR HPC OFFICE USE ONLY

Received (date)	
Amount / cheque	
Application fee	
Interview fee	
Grandfathering Fee	
Trace No.	
Date of Registration	

Approved	Rejected

For all applicants

1 Principle Practice/Employment Address

If you have a practice/employment address you must indicate what it is below:

N.B. If your practice/employment address changes you are responsible for notifying the HPC

2 Personal conduct

Are you, or have you been, barred from the practice of your profession in the UK or any other country? Yes ◯ No ◯

Note: If the answer is Yes you must make a full and separate confidential disclosure of the circumstances.

Have you ever been removed from the register of any professional or regulatory body? Yes ◯ No ◯

Note: If the answer is Yes you must make a full and separate confidential disclosure of the circumstances.

Have you ever had a police caution or a criminal conviction? Yes ◯ No ◯

Note: If the answer is Yes, you must make a full and separate confidential disclosure. Please note that, under UK law, criminal convictions for people working in the health sector, with children, with the elderly and other vulnerable groups never become time-expired.

Are you, or have you previously been, declared bankrupt? Yes ◯ No ◯

3 Health

(Questions on health from Health Committee)

Declaration

If an applicant gains state registration on the basis of incorrect information he / she may thereby gain a pecuniary advantage by deception which may constitute a criminal offence. Inadvertent misrepresentation of information may imperil members of the public who will place a potentially unfounded faith in the skills of the practitioner. The onus for ensuring the full and accurate disclosure of information rests with the applicant.

Treatment of patients for which the practitioner does not have the necessary competence is defined as infamous conduct under the Health Professions Council's Statement of Conduct, and could lead to steps being taken resulting in the practitioner being struck off and rendered ineligible to practise the regulated profession.

- **I declare** that the information given in this document and in all supporting forms is true and accurate. I confirm that I have not made a previous application for registration, and that I have read and understood the Health Profession Council's statement relating to infamous conduct.
- **I understand** that failure to disclose full information, or any deliberate misrepresentation of information, can be a serious matter and will invalidate my application.
- **I apply** for registration to the HPC register and enclose a cheque / money order for a total of £250.

I have completed the direct debit form below. I understand that this direct debit will be set up to pay for my retention fee for future years.

I agree to notify the Health Professions Council in writing, of any change of personal details, for example surname or address, as applicable, of such change occurring.

Signature of applicant _____ **Date** _____

Direct Debit instruction

hpc health professions council

Instructions to your Bank or Building Society to pay by Direct Debit

(Please fill in the form and send to: HPC, Park House, 184 Kennington Park Road, London SE11 4BU)

DIRECT Debit

Name(s) of Account Holder(s)

Originator's Identification Number

9	5	2	2	8	8

Bank / Building Society account number

Registration Number

Branch Sort Code

Name and full postal address of your Bank or Building Society

To: The Manager

Address:

Postcode:

Instruction to your Bank / Building Society

Please pay HPC Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee.

The amounts are variable and will be debited annually on or after 25 June.

I understand that this instruction may remain with HPC and, if so, details will be passed electronically to my Bank / Building Society.

Signature:

Date:

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

DIRECT Debit

This guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme.
The efficiency and security of the scheme is monitored and protected by your own Bank or Building Society.
If the amounts to be paid or the payment date changes HPC will notify you 10 working days in advance of your account being debited or as otherwise agreed.
If an error is made by HPC or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

hpc health professions council

Health Professions Council

Podiatry/Chiropody

Park House • 184 Kennington Park Road • London SE11 4BU

Questionnaire A

This form must be completed by all applicants

*Please use **capital letters** and **black ink** and write in **English** or submit an official translation.*

General Information

Surname or family name - Mr/Ms/Miss/Mrs/Dr/Prof/Other (Circle as appropriate) .....

Forename(s) or first name(s) .....

Address at which you can be contacted during the processing of your application .....

Telephone number at which you can be contacted .....

Date of Birth .....

Full ***current*** name of school where you undertook your training: .....

Full and ***current*** address of school: .....

Telephone/Fax number of school: .....

If the name of the school on your award certificate is different from that indicated above or if it no longer exists, please include an explanatory letter with this form.

Name and position of contact person at school of training .....

I enclose a transcript of my course and a synopsis of the results ◯ *please tick*

1. General Education

1. How old were you when you completed your secondary school education: .....

2. Educational certificates and diplomas obtained during or on completion of full-time school education. Please specify subjects and continue on a separate sheet if necessary.

Year of examination	Subject	Name of Certificate (Education Board)	Grade Attained

2. Details of your professional, academic and other qualifications

Please list in chronological order all post-secondary education–i.e. all academic and other studies since leaving school:

Year of Award	Dates of Attendance Month & Year From / To	Title of Award	Name and Address of Awarding Institution	Full Time (number of years)	Part Time (number of years)

3. Details of attendance at any relevant post-qualification courses in podiatry/chiropody

Please complete the table below, include any relevant post-qualification podiatry/chiropody courses you have attended, **in the last 5 years.**

Course Title and Main Subject	Length of Course Hours	Date Commenced	Date Completed	Full-time or Part time	Qualification obtained if any & Awarding Body

4. Details of employment as a podiatrist/chiropodist

Have you been wholly engaged in the practice of podiatry/chiropody for at least three out of the past two years?

Yes ○ No ○

If yes, we require you to provide the forms of evidence from those listed in the explanatory notes.

Please supply the following information in chronological order about each post you have held since you qualified.

(Indicate the reason for any gaps in practice of one year or longer)

Name and Address of Employer	Employment Dates From To	Full time/ part time. State Hours per week	State title of your post and details of duties (or attach copy of job descriptions)

Self-Employment Address	Self-employment Dates From To	Hours per week	Status eg. Principal, Partner Associate or Other

5. Post-qualification experience (clinical profile)

Please indicate your clinical profile by placing a tick against the heading which itemises your range of clinical experience in managing patients and the clinical environment in each category listed below:

	Clinical practice experience and knowledge of theory		
	Extensive	Some	None
Circulatory conditions			
Neurological conditions			
Musculo-skeletal disorder			
Management of high risk patients (e.g. diabetes, peripipheral vascular disease)			
Management of chronic wounds			
Infection control - instruments & equipment			
Infection control - clinical environment			
Local anaesthesia (injectable)			
Clinical emergencies			
Orthotics prescription			
Orthotics manufacture			
Medicines access & supply			

Other postqualification clinical experience:

6. Pattern of clinical referral

Please indicate your pattern of clinical referral by ticking the appropriate box.

Do you normally treat patients following:	usually	occasionally	never
• Medical practitioner's diagnosis and medical specific [illegible] of treatment required (doctor's direction)	○	○	○
• Medical practitioner's referral for podiatry without direction (you decide treatment)	○	○	○
Do you refer patients to general medical practitioners?	○	○	○
Do you refer patients to other practitioners?	○	○	○

(Please specify) _____

7. References

We need two comprehensive written references, at least one of which should support your stated clinical practice and experience (if any) since qualifying. Please provide the names and addresses of two referees one of whom must be a Podiatrist/Chiropodist whom we can contact.

First Referee

Name _____

Occupation _____ Tel no. _____

Address _____

_____

Relationship to Applicant _____

Second Referee

Name _____

Occupation _____ Tel no. _____

Address _____

_____

Relationship to Applicant _____

8. Personal statement

Please make a personal statement of up to 300 words (preferably typed) in the space below about your experience in the profession, how you keep your professional knowledge up to date and why you wish to be registered to practise podiatry/chiropody.

I declare that all the facts given by me are true and correct and acknowledge that any inaccuracies may affect the decision given to my application.

Signature ..... Date .....

hpc health professions council

Health Professions Council

Podiatry/Chiropody

Park House • 184 Kennington Park Road • London SE11 4BU

Questionnaire B

This form must be completed on behalf of all applicants

*Please use **capital letters** and **black ink** and write in English or supply an official translation.*

General Information

Name of Applicant .....

Address of Applicant .....

Name of Award & Awarding Body .....

Name of Institution .....

Address of Institution .....

.....

.....

Name of person completing form *(in caps)* .....

Position .....

Signature ..... Date .....

About the course

Date applicant commenced the course		Date applicant completed the course		Length of course in academic years	
Total number of taught hours *(excluding clinical hours)*		Total number of taught clinical hours		Total number of modules in course	
How many weeks in an academic year		Total number of private study hours		Mode of attendance p/t f/t accelerated	

Minimum qualifications required for all applicants to enter the course

.....

.....

.....

.....

Subject Knowledge

Please photocopy & complete for each module as required

Module/Subject Specification Form

Module/Subject Title .....

Year of course .....

Pre-Requisite Subjects/Modules .....

Co-Requisite Subjects/Modules .....

Module Structure (Hours)

Lectures		Practicals	
Seminars		Tutorials	
Independent Learning		Assessment Type (e.g. Exam, Oral, Coursework, Project)	
Private Study		Directed Learning	
		Total Hours	

Subject Knowledge

Please photocopy & complete for each module as required

Module Description & Rationale:

Summary of Content/Syllabus:

Learning Outcome:

Teaching/Learning Strategy:

Module Tutors

Module Title	Tutor Title e.g. Mr/Ms/Prof etc	Name
	Module Leader	
	Module Tutors	

Assessment Summary

Please indicate the type(s) of assessment (e.g. examination, oral, coursework, project) and the weighting of each(%) for every module. Continue on another sheet if neccessary.

Title of module	Type of assessment(s)	Weighting	Duration (hours)	Wordcount (if essay)