**LONDON APPROVALS PANEL**

APPLICATION for APPROVAL AS AN approved clinician under the mental health act 1983 (as amended 2007)

|  |  |  |  |
| --- | --- | --- | --- |
| INITIAL |  | RENEWAL  |  |

1. **PERSONAL DETAILS**

|  |  |
| --- | --- |
| Given / First Name(s): |  |
| Surname: |  |
| Please state any other names you have been known by: |  |
| Date of birth: |  |

1. **PROFESSIONAL CONTACT DETAILS**

These details will be visible to users of the Mental Health Act Approvals Register Database

|  |  |
| --- | --- |
| Employing organisation: |  |
| Professional address: |  |
| Postcode: |  |
| Address for MHA Approvals Register Database users to view if different from professional address |  |
| Postcode: |  |
| Landline Number |  |
| Work Mobile Number |  |
| Email address  |  |
| Secretary’s name, phone number and email (**NOT** visible to Approvals Database users): |  |

1. **PRESENT APPOINTMENT**

|  |  |
| --- | --- |
| Role: | Specialty:  |
| Date of Appointment: | Date of End of Appointment (if applicable): |

Locum  Substantive  Retired  Independent  Fixed Term Contract  Training 

Are you working through a Locum Agency? Yes  No  If Yes, please provide agency details in box below:

|  |  |
| --- | --- |
| Agency name: |  |
| Agency address: |  |
| Postcode: |  |
| Telephone number(s): |  |
| Email: |  |

1. **PERSONAL CONTACT DETAILS**

This personal information is for **administrators’ use only** and will not be made public on the Mental Health Act Approvals Register Database.

|  |  |
| --- | --- |
| Home address: |  |
| Postcode: |  |
| Home landline: |  |
| Personal mobile: |  |
| Personal email address: |  |

1. **AVAILABILITY**

**Fee Paying Work Availability:**

These details will be visible to users of the Mental Health Act Approvals Register Database.

Please **clearly** indicate your availability in the relevant box.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Regular working hours: | **Yes ** | **No ** | Out of hours (evening/weekend): | **Yes**  | **No**  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Start Time: |  | End Time: |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mon |  | Tue |  | Wed |  | Thurs |  | Fri |  | Sat |  | Sun |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Tel No |  | Mobile No |  |

1. **LANGUAGES SPOKEN**

Please list below:

|  |  |
| --- | --- |
|  |  |

**The information below is not visible to users of the Mental Health Act approvals database**

1. **AC APPROVAL**

|  |  |  |
| --- | --- | --- |
| Is this your first application for approval? | **Yes ** | **No ** |
| For ST6 applicants only – have you been offered a consultant Acting-up post for which you need AC status? If Yes please enclose confirmation letter from TPD/contract | **Yes ** | **No ** |
| Have you ever been refused approval by another Panel, if so, by which Panel and why? | **Yes ** | **No ** |
| Previous or Current approving Panel (if applicable) | **Expiry Date:** |

1. **PROFESSIONAL HISTORY**

|  |  |
| --- | --- |
| Name of professional body: | **Registration/GMC No:** |
| Is your registration with conditions? (if yes provide details – use a separate sheet if necessary) | **Yes ** | **No** |
| Doctors - Are you on the GMC Specialist Register in Psychiatry? | **Yes ** | **No ** |

1. **PROFESSIONAL QUALIFICATIONS Year Obtained**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

1. **APPROVED CLINICIAN TRAINING**

|  |  |  |
| --- | --- | --- |
| Initial Approval - Have you attended a two day AC Induction training course ratified by an Approvals Panel within the **two** year period immediately preceding the date of this application? | **Yes**  | **No** |
| Re-approval - Have you attended a one day AC Refresher course ratified by an Approvals Panel within the **one** year period immediately preceding the date of your expiry date? | **Yes**  | **No**  |
| Have you booked on a course which is yet to take place? If so, please give details below: | **Yes**  | **No**  |

|  |  |
| --- | --- |
| Course Provider |  |
| Place: |  |
| Date: |  |

(Please enclose a copy of your certificate. If you have yet to attend the training course, please send this once you receive it)

1. **CONTINUING PROFESSIONAL REQUIREMENTS**

|  |  |  |
| --- | --- | --- |
| Psychiatrists - Are you registered with the Royal College of Psychiatrists CPD programme? If, so please supply a copy of your latest Certificate of Good Standing | **Yes**  | **No**  |
| If **not registered** with a CPD scheme, please confirm that you have completed 50 hours (minimum 30 points from Clinical hours) professional CPD over the last 12 months and duly completed the Locality CPD form and this has been approved by your peer group.(If yes, please supply a copy of this) | **Yes**  | **No**  |
| Higher training grade doctors please provide evidence of ARCP/Rita Form | **Yes**  | **No**  |
| Nurses, psychologists, social workers**,** occupationaltherapists – evidence you are up to date within your professional requirements. Please give details on a separate sheet. | **Yes**  | **No**  |

1. **DISCLOSURE AND BARRING SERVICE (FORMERLY CRB)**

|  |
| --- |
| **If you are employed by a an Organisation that is registered by the CQC please contact your HR Department and ask them to contact the Section 12/AC Approvals office with details of your DBS check certificate number, issue date (under three years old) , whether enhanced and whether clear.**If you are not employed by a person or organisation that is registered by the Care Quality Commission (under Chapter 2 of the Health and Social Care Act 2008), eg locum agency please provide a DBS certificate which is clearly dated and less than three years old at the time of applying. |
| Certificate enclosed? | **Yes**  | **No**  |

1. **CURRICULUM VITAE (CV)**

|  |  |
| --- | --- |
|  I enclose a short up to date Curriculum Vitae(Please clearly indicate the reason for any gaps in employment, and if there are periods of part-time working, please clearly indicate WTE) | **Yes**  |

1. **REFERENCES**

Please supply the names, postal and e-mail addresses of two referees. **Referee 1 must have worked with you for a minimum of three months in the preceding twelve months**. **Referee 2** must have known you for a **minimum of three months** in England or Wales (in the preceding 12 months if the referee nominated is an AMPH). Referees must be able to comment on your understanding of and ability to implement the Mental Health Act (1983). The London Approvals Panel has pro forma reference forms which will be sent to your referees.

**One of the referees must be your current or most recent Medical Director or Clinical Director or equivalent**, but where an applicant is on a training programme recognised by the Royal College of Psychiatrists, the referee may be the Training Programme Director or a person the approving body considers equivalent to a Programme Director. **One of the referees must be an Approved Clinician**, the other referee may be drawn from one of the categories listed. (Please indicate which categories apply).

**Referee 1**

* Medical or Clinical Director (medic) or equivalent (for non- medic) 
* (**For higher trainees**) Training Programme Director 

|  |  |
| --- | --- |
| Name: |  |
| Role: |  |
| Contact address: |  |
| Postcode: |  |
| Phone / mobile: |  |
| Email address: |  |

**Referee 2**

* An Approved Clinician 
* Medical or Clinical Director or equivalent 
* Programme Director or equivalent 
* An Approved Mental Health Professional (AMPH) **with whom the applicant has worked within the preceding twelve month**s 

|  |  |
| --- | --- |
| Name: |  |
| Role: |  |
| Contact address: |  |
| Postcode: |  |
| Phone / mobile: |  |
| Email address: |  |

1. **APPLICANT’S DECLARATION**

I understand that if Approved Clinician status is granted, pursuant to this application, my name, employment address and telephone numbers, grade and re-approval date will be added to the Mental Health Act Register Database. The Database is maintained on behalf of the Secretary of State and is used by AMHPs, police, employers, CCGs, courts, prisons. The Data Protection Act 1998 applies.

**I declare the information I have given in this application is true and accurate.**

|  |  |  |  |
| --- | --- | --- | --- |
| **SIGNATURE**: |  | **DATE:** |  |

**(Please sign the form or use an electronic signature)**

**Please note that until all relevant evidence is provided, an application cannot be considered for approval by the Panel**

To be returned to: **Section 12/AC Approval Office, Mental Health Centre, Northwick Park Hospital, Watford Road, Harrow, Middlesex, HA1 3UJ, or by email to:** **s12acadmin.cnwl@nhs.net**

Revised November 2016