**LONDON REGION**

 **CHANGE OF DETAILS FOR APPROVED DOCTORS UNDER SECTION 12(2) OF THE MENTAL HEALTH ACT 1983**

**PERSONAL DETAILS**

|  |  |
| --- | --- |
| **SURNAME** | **FIRST NAME** |
| Please state any other names you have previously been known by |  |
| Date of birth  |  |
| GMC Registration No |  |
| Section 12 Expiry Date |  | Approved Clinician Expiry Date |  |

**PROFESSIONAL CONTACT DETAILS (For the Published Register)**

|  |  |
| --- | --- |
| Employing Organisation |  |
| Professional address |  |
| Phone number(s)  |  |
| Email Address(es)  |  |
| Start date with current post |  | End date(if Fixed Term) : |  |
| Speciality |  |
| Grade (**Academics please give honorary clinical grade)** | Consultant Locum Consultant  | ST4 -6 Locum ST4-6 CT3  | Associate Specialist Staff Grade  Clinical Asst.  | GP Principal  Other (Please Specify) |
| Designation | Locum | Substantive | Retired | Independent | Fixed term contract | Training |

1. **AVAILABILITY**

**Fee Paying Work Availability:**

These details will be visible to users of the Mental Health Act 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 |  | Thur |  | Fri |  | Sat |  | Sun |  |

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

|  |  |
| --- | --- |
| **LANGUAGES SPOKEN** |  |

**PERSONAL CONTACT DETAILS**

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

|  |  |
| --- | --- |
| Home address |  |
| Home phone / mobile |  |
| Email address |  |

**SIGNATURE**.......................................................................... **DATE**.....................................................

**To be returned to**: **Section 12/AC Office, Mental Health Centre, Northwick Park Hospital, Watford Road, Harrow, HA1 3UJ. Tel: 020 8869 3515 Fax: 020 8869 3516 E:** **s12acadmin.cnwl@nhs.net**