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| **Part 1: PERSONAL DETAILS** |

Name: ………………………………………………………

Practice Address: ………………………………………………………

 ……………………………………………………….

 ……………………………………………………...

E-mail: @wales.nhs.uk……….....................

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| W  |   |   |   |   |   |

Practice W-code:

|  |  |  |  |  |  |  |  |
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Date of Birth:

**D D M M Y Y Y Y**

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Superannuation No. (if known)

|  |  |  |  |  |  |  |  |  |
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|   |   |   |   |   |   |   |   |   |

National Insurance No.

Responsible LHB: Please select...

Professional Status: Choose an item.

Please supply a copy of an extract from the signed partnership agreement which confirms your start date as a non GP partner at the practice.

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| **Part 2: PROFESSIONAL REGISTRATION INFORMATION (if applicable)** |

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Date of Provisional Registration with relevant

**D D M M Y Y Y Y**

Professional Body:

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Date of Full Registration with relevant

**D D M M Y Y Y Y**

Professional Body

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Registration No:

**Details of Non-Registered Status**

\*Please give details of any period during which your name was not included, for any reason on the relevant professional body Register

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| --- | --- | --- |
| **From****dd/mm/yy** | **To****dd/mm/yy** | **Reason for Non Inclusion\*** |
|   |   |   |
|   |   |   |

\*Reasons may include: Voluntary Withdrawal; Removal for Non-Payment of Fees; Suspensions; Disciplinary Removal

If you need extra space to complete this section, please attach a separate sheet.

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| **Part 3: ELIGIBILITY FOR SENIOR PREMIUM PAYMENTS** |

|  |  |  |  |  |  |  |  |
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Date of initial appointment as

**D D M M Y Y Y Y**

A non GP partner\*

Please list appointments in chronological order commencing with the most recent to confirm reckonable service.

Reckonable Service

Service with any NHS organisation without a break of three months or more is classed as continuous service.

Continuous employment in this context includes periods of service with any Primary Care Contractor (GP Practice, Dental Practice, Optometry Practice or Community Pharmacy) or NHS employer which includes Health Authorities, NHS Boards, NHS Trusts, Primary Care Trusts and the Northern Ireland Health Services, provided that there are no breaks in service of 3 calendar months or more.

In order to have previous service regarded as reckonable service; staff **must** provide formal documentary evidence of any relevant, reckonable service.

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| **Post Held** | **From/To****dd/mm/yy** | **Employing Authority/ Hospital/Practice** | **Type of Service** | **Part Time Full Time** |
|   |   |   |   |   |   |
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If you need extra space to complete this section please attach a separate sheet.

Breaks in Reckonable Services in the NHS. Please list all breaks in chronological order commencing with the most recent:

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| **From****dd/mm/yy** | **To****dd/mm/yy** | **Reason** |
|   |   |   |
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If you need extra space to complete this section please attach a separate sheet.

Reasons may include career breaks, service overseas, suspension or removal from your relevant Professional Body

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| **Part 4: DECLARATION, UNDERSTANDINGS & CLAIM** |

* I declare that the information on this form is correct and I note that I may be requested to provide documentary evidence to substantiate this claim
* I understand that checks may be undertaken with the NHS Pensions Agency and previous employers
* I understand that the first payment will be provisional and that further payments may be made or recoveries affected following validation of my statements
* I wish to claim payment in accordance with the Partnership Premium Scheme

Signed …………………………………………………….. Date Click or tap to enter a date.

Practice Stamp

Please submit completed forms to: nwssp-primarycareservices@wales.nhs.uk

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|  **OFFICE USE ONLY** |

Application checked &

Spreadsheet updated by ………………………………….. Date… ………………………….

Application authorised and

Spreadsheet details

checked by ………………………………….. Date… ………………………….

Reckonable years’ service verified ………………………………….. Date… ………………………….

Signed partnership agreement verified ……………………………… Date… ………………………….

K:\Services\Contracts Management\General Departmental Information\(Pontypool) Departmental Filing\Agendas & Minutes\Partnership Premium Payment\PPF2 Partnership Premium Form v1.docx