

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

Alternatively please print out and complete using BLACK INK and BLOCK CAPITALS and return by post to:
Occupational Therapy Office, PO Box 188, Menlyn 0063, South Africa

Section A – Membership start date and personal details

If your application for membership of MPS is approved, it will be dated from the day following receipt of your application unless you specify a later start date in the box to the right: (DD/MM/YYYY)

Title		Country of practice	
First name		Country of permanent residence	
Middle name		Address for correspondence	
Surname			
Maiden/previous name (if any)			
Date of birth (DD/MM/YYYY)		Postcode (zip or postal area)	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Email address	
Nationality		Home/private telephone	
Degrees and diplomas		Work telephone	
Medical school and country		Cell number	
Month and year of graduation		Fax number	

HPCSA details – your application may be delayed if this is not provided

HPCSA No.
HPCSA Registration date

Practice category (please tick all that apply)

Private practice Government/State
 Other (please specify)

IMPORTANT – Please read the following

1. If you have had previous indemnity or insurance we may approach your previous indemnity provider or ask you to obtain a copy of your claims history.
2. Failure to disclose full and accurate details about your previous history, practice and income may invalidate your membership which means you are not entitled to seek advice or assistance from MPS.
3. When completing the previous history section on pages 2 and 3 you must account for any gaps in your indemnity or insurance history during the last 10 years and also any break in clinical practice during the previous 2 years.
4. We will not assist with any matter arising from an incident pre-dating your MPS membership.
5. If you are leaving a claims made insurance contract, please ensure you have notified your previous provider of any adverse incident of which you are aware, that could become a claim. You should also check with the provider whether any closing payment is required to secure “run-off” cover for any future claim which may arise from an incident pre-dating your MPS membership.

Please note that signing the declaration on page 6 indicates acceptance of the following requirements:

Members must keep MPS informed of their current address and any changes in their professional circumstances. Failure to notify us of any change of address or scope of practice could result in the suspension and/or the withdrawal of the benefits of membership and/or the cancellation and/or the termination of your membership. Members should understand that MPS is not an insurance company. The benefits of MPS membership are granted at the discretion of Council and are subject to the terms and conditions of the MPS Memorandum and Articles of Association, as amended from time to time.

Section B – Previous history (Please read the important information below)

In this section you must include details of any matter in which you have been named or involved. Please include any pending, unresolved or closed issues, even those already reported to MPS. If necessary please continue your answers on the enclosed pages. Please note that failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

1. Have you had any professional indemnity/insurance before?

If YES, please give the name of all other organisations and the dates during the last 10 years which you were a member or policyholder. If you were previously a member of MPS, please give your membership number and your full name at the time (if it has changed).

Yes No

Organisation	From date (DD/MM/YYYY)	To date (DD/MM/YYYY)	Membership/policy number

2. Will you carry out professional practice outside of the country in which you are applying for membership? If YES, please give details of which countries and the amount of work below.

Yes No

3. Will you be involved in treating or providing advice to patients outside of the country in which you are applying for membership? This includes remote consultation and prescriptions, if YES, please give details.

Yes No

4. Have you at any stage practiced without professional indemnity during the last 10 years? If YES, please confirm the dates and the reasons below. Please exclude any period(s) protected by state, employer, insurer or MDO indemnity.

Yes No

5. Have there been any breaks in your clinical practice of more than 6 months in the last 2 years? If YES, please confirm the dates and reason for the gap along with any continuous professional development or refresher training.

Yes No

6. Have you ever previously been refused professional indemnity or insurance, including a decline to renew, or had it withdrawn/voided? If YES, please give a summary of events, dates and reasons below. Please include copies of any relevant correspondence.

Yes No

7. Have you had any non-standard terms or conditions including a non-standard subscription or premium imposed on your professional indemnity or insurance? If YES, give a summary including events, dates and reasons.

Yes No

8. In the last 10 years, have you had any complaints arising out of your practice that were not resolved at a local level? If YES, please give a factual summary of the event, the extent of your involvement, the country, relevant indemnifiers and outcomes.

Yes No

9. In the last 10 years have you been involved in any claim(s) for compensation or damages arising out of your professional practice regardless of the outcome? If YES, please give a factual summary, your involvement, indemnifiers and outcomes.

Yes No

10. Are you aware of any incident(s) or complaint that might become a claim? If YES, please give a factual summary of the event, the extent of your involvement, the country, relevant indemnifiers and outcomes.

Yes No

11. Have you ever been the subject of a disciplinary inquiry or had practice privileges refused/withdrawn/made conditional by a health care provider? If YES, please give details below. Please include copies of any outcome letters/documentation with your application.

Yes No

12. Have you ever been subject to any referral, complaint, inquiry, investigation or hearing by any regulatory, licensing or registration body? If YES, please give details below. Please include copies of any outcome letters/documentation with your application form.

Yes No

13. Are there any other issues of which MPS might need to be aware when considering your application for membership? If YES, please give details below.

Yes No

14. Have you been cautioned by the police or convicted of any criminal offence? If YES, please give details below. Please do not include minor traffic offences.

Yes No

IMPORTANT – If you have answered Yes to any of the above questions please complete the following giving details as outlined in the question above. Please DO NOT provide patient sensitive or confidential information such as patients name and address information

Question no.	Date	Outcome	Cost	Summary (please refer to the question above for what information is needed)

Section C – Declaration

IMPORTANT – Your personal information and data

When interacting with MPS, you may choose to give MPS information about your criminal convictions and offences (including alleged offences), your health, race, ethnic origin, sex life, sexual orientation and trade union membership ('Special Category Data'). This happens where that information is relevant to your membership or the actual or potential provision of advice, assistance or indemnity. We may also receive Special Category Data about you from others in connection with membership or advice, assistance or indemnity (eg from a complainant, claimant, witness, expert, court or regulator).

To find out more about how we collect, use and handle your data including Special Category Data, please see the Privacy Statement on our website medicalprotection.org/privacy

When you tick the box below, you expressly consent to MPS processing your Special Category Data for the purposes of providing you with membership and its benefits (including assistance and indemnity).

I consent

You may withdraw consent to such processing by contacting MPS, but if you do so we will no longer be able to provide you with membership and its benefits.

IMPORTANT – Please read, sign and add the current date below

By signing and returning this form, you agree and confirm that:

- i. You wish to apply for membership of MPS subject to the Memorandum and Articles of Association.
- ii. You understand that any failure to disclose full and accurate details may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.
- iii. You understand that membership is not conferred automatically and is subject to approval by MPS.
- iv. You acknowledge that any subscription payments made are subject to verification and that acceptance of a payment by MPS does not of itself confirm membership and/or entitlement to request benefits.
- v. You will inform us if your personal circumstances or scope of practice change.
- vi. We may seek information from other professional defence organisations, insurance companies, employers, and/or other third parties in respect of membership and that they may release to us such information.
- vii. For the purposes of the South African law and The Protection of Personal Information Act (4 of 2013), we may obtain, process, retain and transfer your personal data as set out in the Privacy Statement on our website medicalprotection.org/privacy

Date

Please note this must be the current date

Tick here if you are submitting additional sheets or correspondence.

In order to provide you with the best possible service we would like to inform you of other products and services offered by us that we believe may be of interest to you. To opt-in to receive such information, either via post or email, please tick here.

You can contact us to update your marketing preferences.

Please tell us why you have chosen MPS – Your comments are important to us, please tick below

- | | | |
|----|--------------------------|---|
| 1. | <input type="checkbox"/> | Personal recommendation |
| 2. | <input type="checkbox"/> | Competitive subscription rates |
| 3. | <input type="checkbox"/> | MPS membership co-ordinator, please provide their initials: |
| 4. | <input type="checkbox"/> | Group arrangement |
| 5. | <input type="checkbox"/> | Dissatisfaction with previous organisation |
| 6. | <input type="checkbox"/> | Other (please provide details) |



Medical Protection – South Africa

A scheme of co-operation between Medical Protection and OTASA – Occupational Therapy Association of South Africa

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South Africa

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othoffice@othoffice.co.za

Additional space for answers

Please clearly indicate the question number that you are providing details for below.