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GST No. 99-279-141

# DISCLOSURE AND REFEREE FORM FOR LOCUMS

**NAME:**

**DATE OF BIRTH:**

**CONTACT DETAILS (EMAIL & PHONE):**

## DISCLOSURES

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Have you ever been or are you now the subject of any malpractice claims incidences or allegations? | | | Have you ever been or are you now the subject of any civil or criminal investigations, or allegations or charges? | | |
| Are you now or have you ever been under the supervision of a doctor for any emotional, psychological or other conditions or illnesses which might have an impact on your performance as doctor? | | | Are you now or have you ever been the subject of any investigations, sanctions, revocations or suspensions of your medical registrations (licenses) or prescribing authority? | | |
| Have you ever been denied membership in or privileges at or otherwise been investigated, sanctioned or reprimanded by any medical institution, society or association? | | | Do you or any family member who will accompany you have any illnesses or disabilities that might preclude you from receiving a foreign visa on medical grounds? | | |
| Are you or have you ever been addicted to any drugs or alcohol? | | | Are you HIV or HEP B positive? | | |

## REFEREES

Name, contact phone numbers and email addresses for two or three current professional referees/source of testimonials. Please note that applicants will be notified prior to referees being contacted.

Name/Position_____

Association to Referee_____Tel:_____

Email address:_____

Name/Position_____

Association to Referee_____Tel:_____

Email address:_____

Name/Position _____

Association to Referee _____Tel:_____

Email address:_____

I consent to Hospital Staff Solutions seeking verbal or written information about me from the above-named and authorise the information sought to be released to potential employer as agreed by undersigned.

## DECLARATION

I _____(full name) declare that to the best of my knowledge the answers provided in this application are correct, and I understand that if any false or misleading information is given or any material fact suppressed I will not be accepted, or if I am employed my employment will be terminated. I also understand that any false information given in relation to my medical history may result in my loss of entitlement to any compensation from ACC.

**APPLICANT'S SIGNATURE:**_____**DATE:**_____

*Please submit this form with a copy of your CV, Annual Practising Certificate and MPS to:* ***angela.shaw@hospitalstaff.co.nz*** *or fax to: 09 446 3331*