- Agenda Item 6
 - Enclosure 4

Paper RC 11 / 02

REGISTRATION COMMITTEE

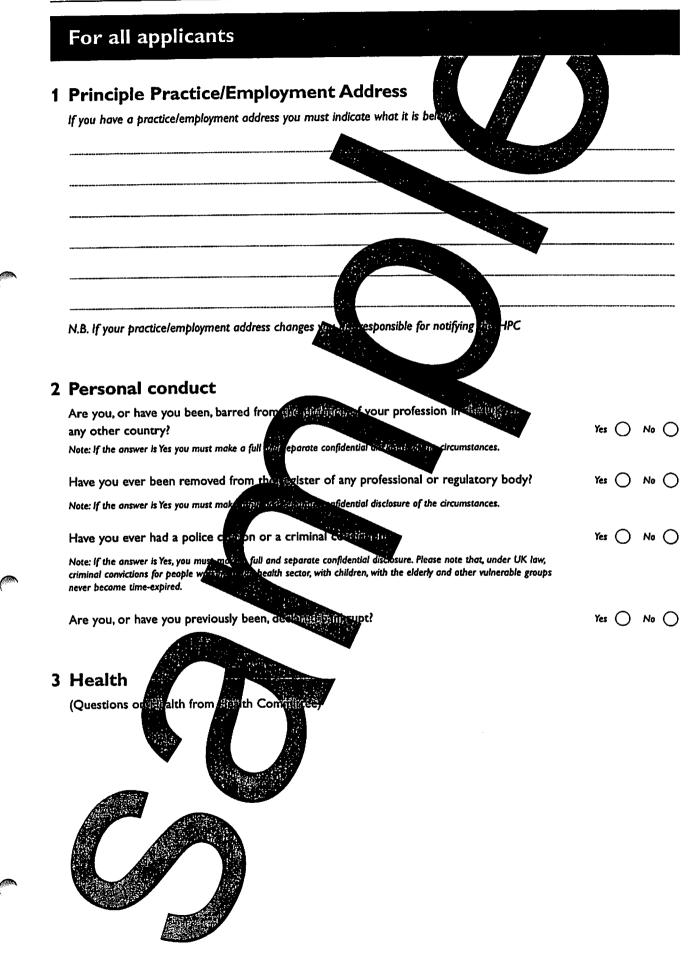
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CHIROPODISTS GRANDFATHERING FORM

From : Secretary to the Committee

hn	Healt	h Professic	ons Counc	il		
health profe count	ssions	se•184 Kenning	on Park Road •	London SEAL BU		'
All applicants v	who wish to be consid Failure to	ered for state regist do so will result in ake an application	tration under the delays in process will <u>ally cast fro</u>	of OrderSilp Coun Grandfathatics route r sing and will success m	nist comple	ete all services of this form
Personal	Informatio	n				
Please use bloc	k capitals only throu	ghout this applica	tion form. In add	ition the use of black	all dates	n would facilitate copyin
Surname or fa	imily name - Mr/M:	s/Miss/Mrs/Dr/Pr	of (D <u>àrsa</u> às appn	opriate)		
Forename(s)	or first name(s)					******
Date of birth						
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Nationality					Se	ex Male 🔿 Female
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Declaration

If an applicant gains state registration on the basis of incorrect information the / she nave hereby gain a pecuniary advantage by deception which may constitute a criminal offence. If the ertent misrepresentation of information may imperil members of the other lic where il place a potentially unfounded faith in the skills of the practitioner. The onus for source the full and incurate disclosure of information rests with the applicant.

Treatment of patients for which the practition of have the necessary and the second se as infamous conduct under the Health Professions Couties Statement of Conduct, and could lead to steps being taken resulting in the practitioner being statisticand rendered ineligible to practise the regulated profession.

- that the information given in this document and in all in all in the forms is true and • I declare accurate. I confirm that I have no register previous application for registration, and that I have read and under a contract the interview of the second sec to infamous conduct.
- that failure to disclose full information, or any different misrepresentation of information, can be a service matter and will invalue my application. • I understand
- for registration to the HBC and so and enclose a cheque the ley order for a total of £250. • I apply

I have completed the direct debit form below a mitestand that the meet debit will be set up to pay for my retention fee for future years.

I agree to notify the Health Professions Council in writing, and any of personal details, for example surname or address, as and the such change occase

Signature of applicant

Direct Debit instruction

To: The Manager

Addres

Instructions to work Bank on Billding Society to pay by Direct Debit (Please fill in the for the add to: HPC, Pan. Provide and Kennington Park Road, London SE11 4BU)



Name(s) of Account Housen(s)

Originator's Identification Number

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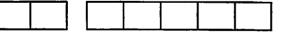
Bank / Building Social Social



Name and full postal and ress of your Bank or Building Society

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Registration Number



Instruction to your Bank / Building Society

Please pay HPC Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee.

The amounts are variable and will be debited annually on or after 25 June.

I understand that this instruction may remain with HPC and, if so, details will be passed electronically to my Bank / Building Society.

Signature:

Date:

This guarantee should be detached and retained by the payer.



DIRECT

This guarantee is offered by an Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the scheme is monitored and protected by your own Bank or Building. Society.

ode:

If the amounts to be paid or the payment date changes HPC will notify you 10 working days in advance of your account being debited or as otherwise agreed. If an error is made by HPC or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid. You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.



Questionnaire A This form must be completed by all optimizants Please use capital letters and black inkertidewrite in English or subtitive opticial state stion.

General Information

Surname or family name - Mr/Ms/Miss/Mrs/Dr/Prof/Other (Circless response)

Forename(s) or first name(s)

Address at which you can be __ contacted during the processing of your application

Telephone number at which you can be contacted

Date of Birth

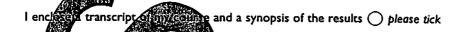
Full current name of school when you undertook your training:

Full and *current* address of school:

Telephone/Fax number of school:

If the name of the pool on your award conjugate is different from that indicated above or if it no longer exists, please includes a explained ry letter which this form.

Name and position of contact encoded action of training

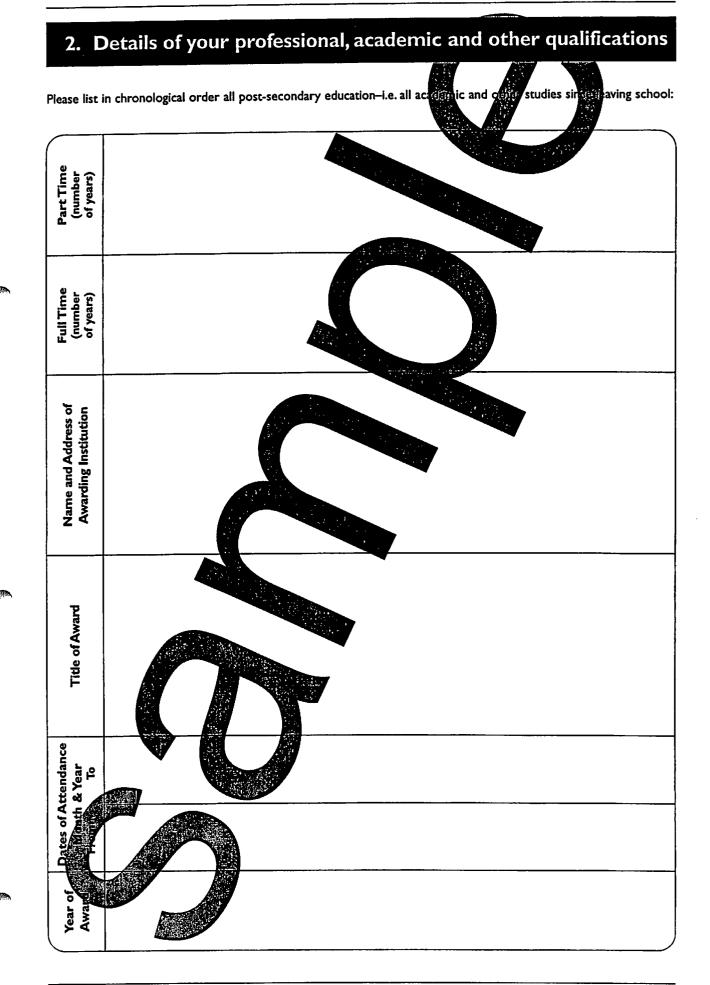


1. General Education

1. How old were you when you completed your secondary school education

2. Educational certificates and diplomas obtained during or on completion output the school education. Please specify subjects and continue on a separate sheet if necessary

Year of examination	Subject	(Education Certificate (Education Roard)	Grade Attained
			•
			_



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3. Details of attendance at any relevant post-qualification courses in podiatry/chiropody

Please complete the table below, include any relevant you have attended, in the last 5 years.	post-qualification	poill try/chire) say	courses

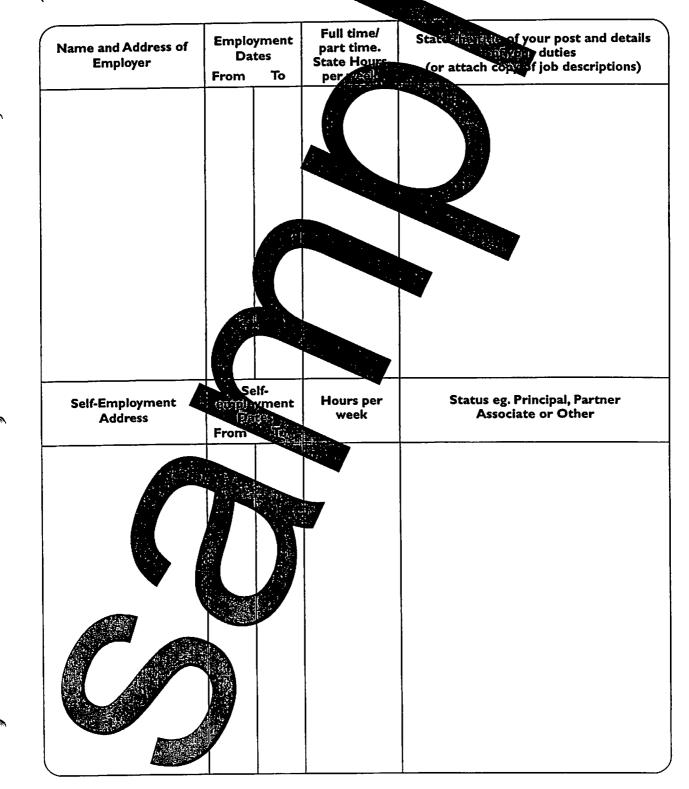
Course Title and Main Subject	Length of Course Hours	Date Commenced	विद्यात. इन्होंने क्रिया	Full-time or Part	& Awarding Body	
	\bigcup					

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4. Details of employment as a podiatrist/chiropodist

Have you been wholly engaged in the practice of podiatry/chiropody for a transfer three outpout he past the pars?

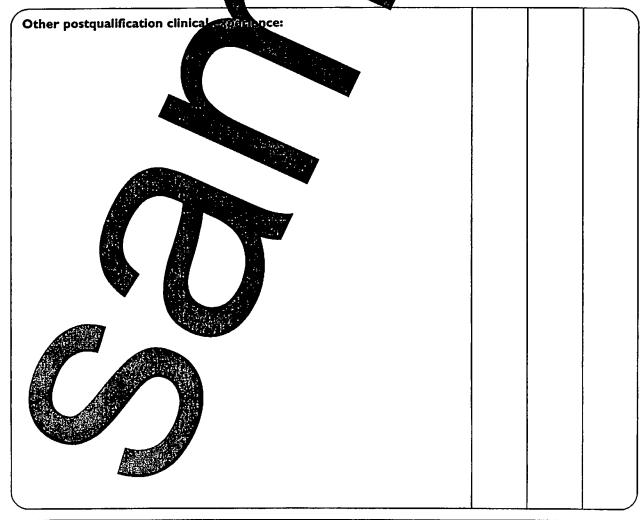
If yes, we require you to provide the forms of evidence from those listed in the probability of the provide the forms of evidence from those listed in the probability of the probabilit



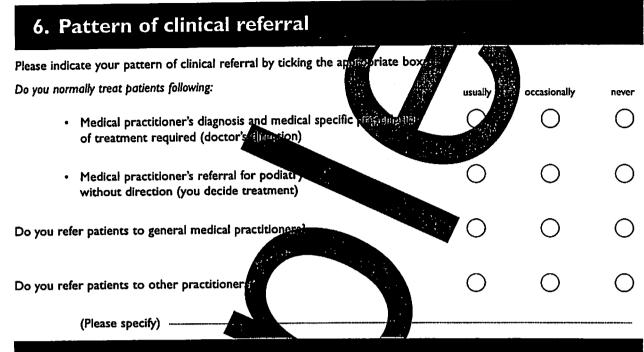
5. Post-qualification experience (clinical profile)

Please indicate your clinical profile by placing a tick against the heading will be itemised with a profile of clinical experience in managing patients and the clinical environment in each category listed with ow:

		ge of theo	ry
Circulatory conditions	Extensive	Some	None
Neurological conditions			
Musculo-skeletal disorder			
Management of high risk patients (e.g. diabetes, peripipheral vascular disease)			
Management of chronic wounds			
Infection control - instruments & equipment			
Infection control - clinical environment			
Local anaesthesia (injectable)			
Clinical emergencies			
Orthotics prescription			
Orthotics manufacture			
Medicines access & supply			

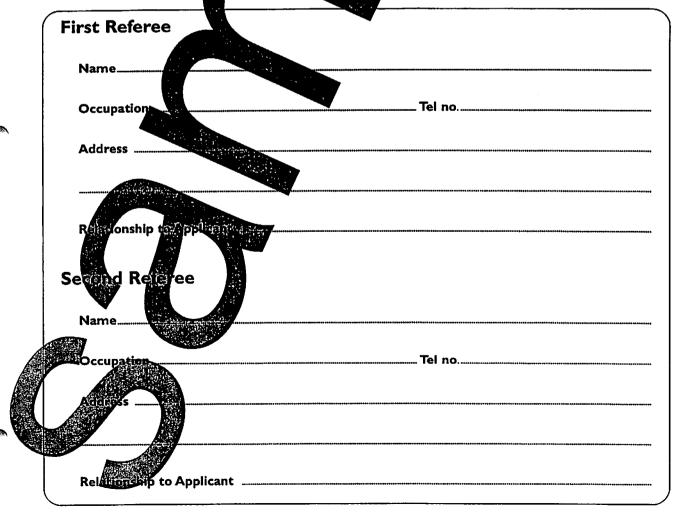


Podiatry/Chiropody 7



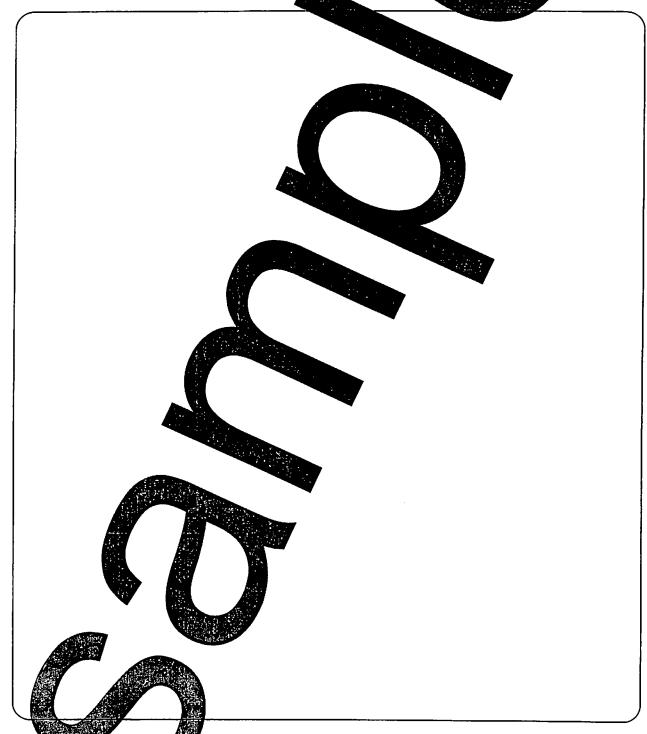
7. References

We need two comprehensive written difference at least one of with a support your stated clinical practice and experience (if any) since qualifying. Please states in the names and address of two referees one of whom must be a Podiatrist/Chiropodist when the can contact.



8. Personal statement

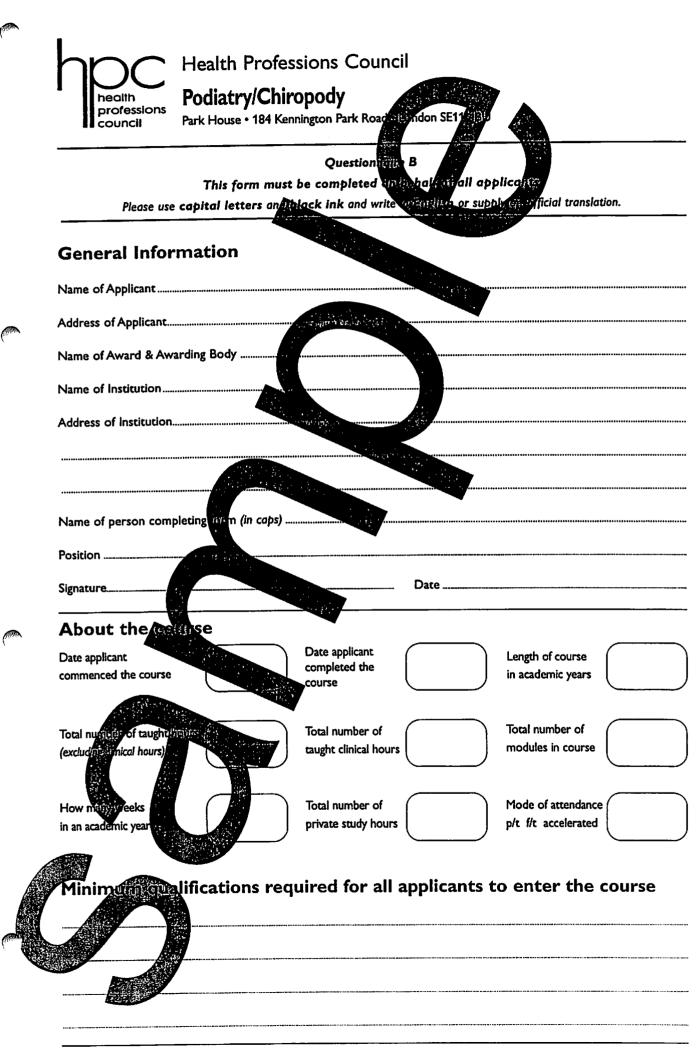
Please make a personal statement of up to 300 words (preferably typed) there space your about you experience in the profession, how you keep your professional knowledge up to date an up to your you for to be registered to practise podiatry/chiropody.



I decaye that all the facts given by me are true and correct and acknowledge that any inaccuracies may affect the decision given to my application.

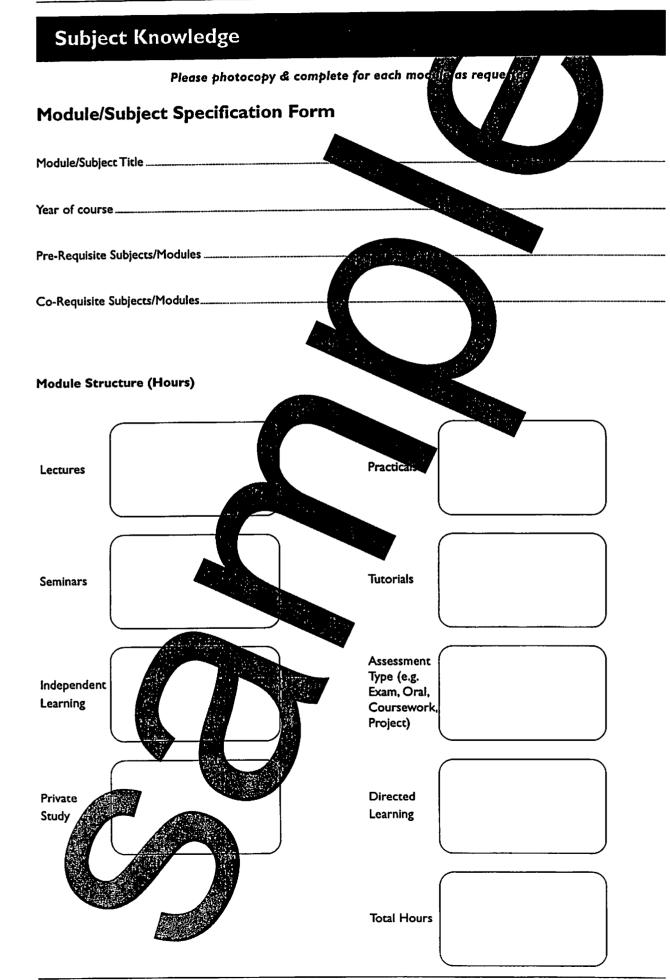
Signature

Date

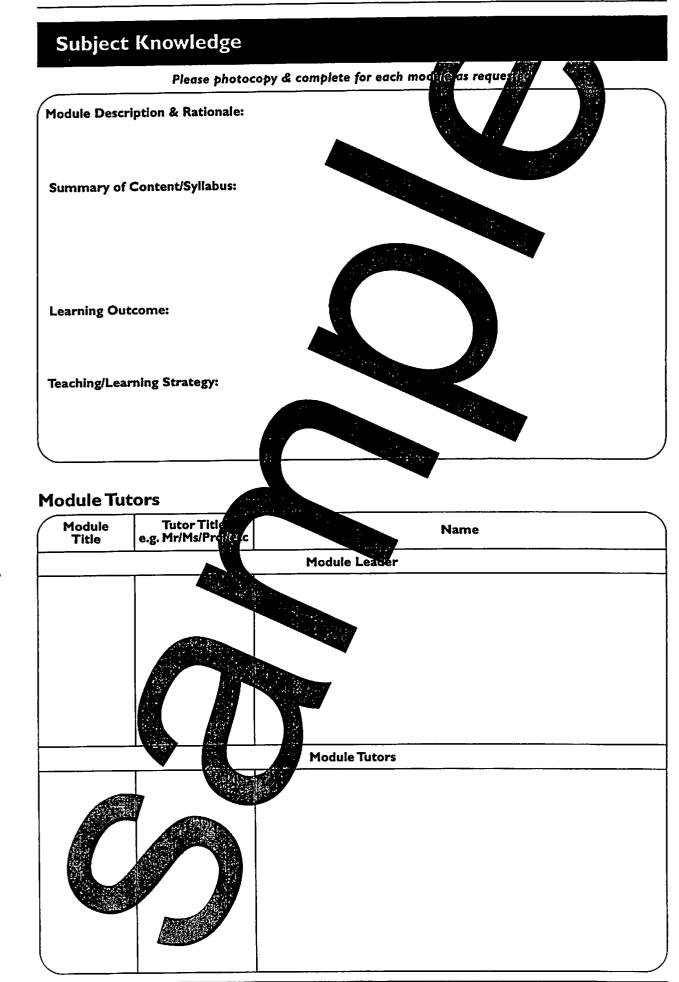


POD-QB-020515

2 Health Professions Council



Podiatry/Chiropody 3



POD-Q8-020325

4 Health Professions Council

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or every	module. Conti	inue on another sheet if	neccessary.		
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