

DECLARATION OF ANY LOSS OR SURRENDER OF MEDICAL LICENSE TO PRACTICE OR HOSPITAL SUSPENSIONS

It is important for MidCentral District Health Board to identify whether potential Senior Medical staff members have lost or surrendered their License to Practice Medicine or have been suspended from any hospital during their career. We understand and respect an applicant's right to privacy and the information on this declaration will only be used for the purpose of determining whether an applicant is suitable for employment.

If you have lost or surrendered your License to Practice Medicine or have been suspended from any hospital during your career, complete Section B of the declaration and place in the sealed envelope provided. This information will be viewed by an Human Resources Consultant and the Medical Adviser only. These staff will determine your suitability for employment. Your information will remain confidential to these staff.

SECTION A

To be completed by applicants who have not lost or surrendered their License to Practice Medicine and have not been suspended from any hospital during their career.

I, (full name) _____

declare that I have never lost or surrendered my License to Practice Medicine and have not been suspended from any hospital during my career.

_____ Signature _____ Date

If misleading or incorrect information is given on this declaration and you are appointed to a position, you may be dismissed from employment for provision of incorrect information.

SECTION B

To be completed by applicants who have lost or surrendered their License to Practice Medicine or have been suspended from any hospital during their career.

I, (full name) _____

declare that I have lost or surrendered my License to Practice Medicine on the following occasions and for the following reasons and/or have been suspended from the following hospital(s) during my career for the reasons listed.

(If you wish you can add any comments relating to the above and your suitability for employment in the position you have applied for within MidCentral District Health Board.)

_____ Signature _____ Date