



South East London Doctors' Co-operative

## MEMBERSHIP APPLICATION FORM

NAME: \_\_\_\_\_

PRACTICE \_\_\_\_\_

GMC Registration  
Number: \_\_\_\_\_

Defence Organisation: \_\_\_\_\_

Membership Number: \_\_\_\_\_

Name of PCT  
\_\_\_\_\_

Clean Driving Licence      YES                                  NO  
\_\_\_\_\_

Are you on the  
supplementary list      YES                                  NO  
\_\_\_\_\_

I hereby declare that I have read the Terms and Conditions of SELDOC membership and agree to be strictly bound by them.

Signed \_\_\_\_\_

Dated \_\_\_\_\_



South East London Doctors' Co-operative

## PRACTICE INFORMATION

Please complete all details in the form below.

a) The name its patients generally know the Practice.

.....

b) The Practice full address and contact details (please give details of any other branch surgeries)

	Main Practice	Branch Surgery
Address		
Practice Manager		
Telephone		
Bypass		
Practice Mobile		
Fax		
Email		

Practice List Size: \_\_\_\_\_

Half Day? \_\_\_\_\_



South East London Doctors' Co-operative

## DOCTOR INFORMATION

(Please duplicate this form as necessary)

Please complete the details below. Please include details for partners, trainee's assistants and regular locum doctors. If there are doctors that are NOT joining SELDOC but participate in practice rota, please ensure that they complete the separate form (details on request). Details marked \* need not be disclosed if preferred.

Surname	First Name (name doctor is known by)
---------	--------------------------------------

Home Address:

.....

.....

.....

.....

Status*  Salaried / Principal	FHSA Number (Health Authority No)
-------------------------------------	-----------------------------------

Prescribing Code .....

Email Address .....

Home Telephone Number	Mobile Phone Number
Pager Type (eg. BT Message Master)	Pager(s) If there is more than one pager, please indicate which you preferred to be alerted on:

**BANK DETAILS**

**For Sessional Payments**

Members
Name: _____
Practice
Address: _____
_____
_____
_____
Bank Name: _____
Branch: _____
Bank Address: _____
_____
Sort Code: _____
Account
Number: _____
Account Name: _____
_____

Signed.....

Date.....

Payment for Sessional payments will be made by **direct debit** into this account on or around the 14<sup>th</sup> day of the month following the month in which the sessions were carried out.



South East London Doctors' Co-operative

## Practice list size information

Practice: .....

Practice Manager:.....

Practice List Size :.....

We hereby give the authority/consent to SELDOC to obtain our list size from the PCT directly.

Signed:.....Date:.....

***Also, Be assured that this information will be held in the strictest confidence at all times.***

*Please return the forms together with copies of GMC and MDU/MPS certificate of each Doctor.*