SCHEDULE 2

Regulations

FORM OF APPLICATION
GIBRALTAR HEALTH AUTHORITY
MEDICAL (GROUP PRACTICE) SCHEME

Application for Registration

Please fill in the following details:

Surname: _____

First Name: _____ Initial(s): _____

Address:_____

Nationality: _____

Tel. No:. _____ Date of Birth: _____ Sex:_____

No. of dependants:_____ I.D. No. _____

Doctor: _____ Blood Group:_____

Are you diabetic? Yes/No Are you a blood donor? Yes/No

I of
hereby declare that the above particulars are true to the best of my knowledge and belief. I acknowledge that it is an offence wilfully to make any false statement or any material misrepresentation in this application, with the intention of obtaining or attempting to obtain any benefit to which I or any of my dependants are not entitled.

being a person who is * insured/not insured under the Social Security (Employment Injuries Insurance) Act and or the Social Security (Insurance) Act apply for registration as a member of the Medical Group Practice Scheme.

DATE: _____ SIGNED: _____

Please complete a form in respect of each of the dependants for whom an application for registration is being made.

For office use only:

Health Centre No. Registration No. Zone
Category Renewal

Gibraltar Health Authority
Medical (Group Practice) Scheme

Application for first time applicants

Contact Details Home No. Work No.

Mobile No. Email Address

SECTION A

Religion (Optional)

Ethnicity

Marital status (Please tick appropriate box)

Single ☐ Married ☐ Civil Partne ☐ Divorce ☐ Widow ☐ Cohabitee ☐

SECTION B (To be filled in by Pensioners, Unemployed, Retired or District Medical Services)

My income per month is as follows

DETAILS PER MONTH	SELF	SPOUSE
INCOME FROM EMPLOYMENT IF ANY		
OCCUPATIONAL PENSION		
OLD AGE PENSION (O.A.P)		
HOUSE COST ALLOWANCE (COMMUNITY CARE)		
MINIMUM INCOME GUARANTEE (M.I.G)		
DISABILITY ALLOWANCE		
DISABLEMENT BENEFITS		
MAINTENANCE ALLOWANCE		
DISTRICT MEDICAL SERVICES		
ANY OTHER INCOME		
TOTAL INCOME =		

SECTION C (To be filled in by all applicants)

NEXT OF KIN

Surname

First and middle names

Address

Post Code

Contact Details Home No. Work No.

Mobile No. Email Address

Relation (Please tick appropriate box)

Spouse ☐ Child ☐ Civil Partner ☐ Relative ☐ Carer ☐ Foster Parent ☐

Parent ☐ Sibling ☐ Social Services ☐ Other (Please Specify)

SECTION D (To be filled in by all applicants)

Please select a GP from the list below. (If applying for the first time you may wish to discuss this with a registration officer).

Dr K Alvarez ☐	Dr D Higgins ☐	Dr L Penrice ☐
Dr Baynham ☐	Dr S Jones ☐	Dr E Pincho ☐
Dr N Chichon ☐	Dr S J Lima ☐	Dr R Pinto ☐
Dr P Cortes ☐	Dr S Lines ☐	Dr N Perez ☐
Dr A Falero ☐	Dr J Manasco ☐	Dr M Poyatos ☐
Dr J Ferrera ☐	Dr D Martyn ☐	Dr K Rawal ☐
Dr E Flores ☐	Dr F Mena ☐	Dr A Skinner ☐
Dr V Flores ☐	Dr R Meta ☐	Dr J Thoppil ☐
Dr O Gonzalez ☐	Dr N Montero ☐	Dr Y Robles ☐
Dr A Gupta ☐	Dr J Negrette ☐	

Kindly note that if you are submitting your application electronically, you should receive an automatic reply, confirming receipt. If for any reason you do not receive an automatic reply, please contact us on 20007860

Data Protection – How we use your information.
We treat all the information you give us about you and others as private and confidential. We respect your right to privacy and understand the importance of protecting the personal information we hold. See our privacy notice for full details.