

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.
Category

Registration No.
Renewal

Zone

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 Partner Divorced Widow Cohabitee

Please complete if you are in receipt of a state pension (Please tick appropriate box).

Gib Pensioner Gib and UK Pensioner UK Pensioner Other (please specify)

SECTION B (To be filled in by individuals applying on the grounds of low income).

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.