

Overseas Registration: Health Verification



International Registrations, 23 Portland Place, London, W1B 1PZ Phone: +44 20 7333 6600 Web: www.nmc.org.uk

To the applicant: This section must be completed by the occupational health department where you are currently employed or by a registered medical practitioner. The declaration must be no more than three months old at the time the application for registration is submitted to the NMC. If the declaration is expired we will ask you to provide a current declaration.

To the REGISTERED MEDICAL PRACTITIONER/OCCUPATIONAL HEALTH DEPARTMENT representative:

The applicant named below has recently submitted an application to register with us. They've told us that you will be able to verify the information they've provided to us. So they can continue their application, we need you to confirm that the information they provided is correct and matches your records.

They have confirmed that you have been informed that we will contact you and have given us their consent to do so.

We need to know that people applying to join the register meet our health requirements to ensure they can practise safely and effectively.

Please enter your details below and complete the questions that follow. You must be an occupational health department representative or a registered medical practitioner.

Please complete all sections and provide any further details which you may consider relevant on a separate sheet. The NMC may make further enquiries of the applicant or yourself in order to verify or clarify any part of this reference.

Applicant's details

Name of applicant

PRN

Date of birth (DD/MM/YYYY)

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Registered Medical Practitioner's / OH Practitioner's details

Your name

NMC PIN (if applicable)

Job title

Organisation name

Address Line 1

Address Line 2

Town/City

Postcode/Zip code

Country

Email address

Telephone number

Health Verification (continued)

Is your profession regulated?

Yes ☐ No ☐

Your regulator name: _____

Your registration number: _____

As part of their application the applicant has told us that: they have no health condition or disability that could affect their practice.

Do you declare, based on your current knowledge and assessment of the applicant, that you agree with the information they have provided about their health?

Yes ☐ No ☐

If you have answered No above please provide your reason(s)

Health condition(s) and/or disability

If the applicant has declared that they have a health condition and/or disability OR you have told us that they do, please complete this section.

Based on your health assessment do you feel the health condition and/or disability is being managed appropriately to enable safe and effective practice?

Yes ☐ No ☐

If you wish to provide any further supporting information you may enter it here or attach another document together with this form when you email it to us.

I declare that the information I have provided is true and accurate to the best of my knowledge.

Date (DD/MM/YYYY)

Signature