

REQUEST FOR ACCESS TO RECORDS UNDER THE FOI ACT, 1997 AS AMENDED

PLEASE USE BLOCK CAPITALS

APPLICANT DETAILS

SURNAME:	
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FIRST NAME(S):	
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ADDRESS:	

TELEPHONE NUMBERS:	MOBILE:
	HOME:
	BUSINESS:

E MAIL ADDRESS:	
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FEES

INFORMATION INDICATING WHEN FEES ARE REQUIRED IS AVAILABLE ON OUR WEBSITE WWW.MEDICALCOUNCIL.IE. PLEASE REFER TO THIS INFORMATION BEFORE SUBMITTING YOUR REQUEST.

DETAILS OF REQUEST

IN ACCORDANCE WITH SECTION 7 OF THE FREEDOM OF INFORMATION ACT, 1997 AS AMENDED, I REQUEST ACCESS TO RECORDS WHICH ARE (PLEASE TICK AS APPROPRIATE):

PERSONAL NON-PERSONAL

PERSONAL INFORMATION

BEFORE YOU ARE GIVEN ACCESS TO PERSONAL INFORMATION, PROOF OF IDENTITY SUCH AS A PASSPORT OR DRIVING LICENCE MAY BE REQUIRED. ACCESS TO PERSONAL INFORMATION RELATING TO ANOTHER PERSON WILL NOT NORMALLY BE GIVEN UNLESS THE WRITTEN CONSENT OF THAT PERSON HAS BEEN OBTAINED.

PLEASE DESCRIBE IN AS MUCH DETAIL AS YOU CAN, THE RECORDS TO WHICH YOU ARE SEEKING ACCESS. IF YOU ARE LOOKING FOR PERSONAL RECORDS, PLEASE PROVIDE THE FULL NAME OF THE PERSON TO WHOM THE RECORD RELATES. IF THE PERSON IS A DOCTOR, HIS OR HER REGISTRATION NUMBER SHOULD BE GIVEN, IF AVAILABLE.

I REQUEST THE FOLLOWING RECORDS:

FORM OF ACCESS

MY PREFERRED FORM OF ACCESS TO RECEIVE COPIES OF THE RECORDS IS: (PLEASE TICK AS APPROPRIATE):

POST OTHER (PLEASE SPECIFY)

COMPLETED FORM TO BE SENT TO:

**FREEDOM OF INFORMATION OFFICER,
MEDICAL COUNCIL, KINGRAM HOUSE, KINGRAM PLACE, DUBLIN 2.**

FOR OFFICE USE ONLY

DATE REQUEST RECEIVED:	
IDENTITY VERIFIED:	
CONSENT CONFIRMED:	