YOUR REGISTRATION NUMBER: | | | | | | |

Form TSR1 APPLICATION FOR REGISTRATION IN AN INDIVIDUALLY NUMBERED IDENTIFIABLE TRAINING POST

Comhairle na nDochtúirí Leighis
Medical Council

Kingram House, Kingram Place, Dublin 2.
Telephone: +353-1-4983100
Facsimile: +353-1-4983102
Email: registration@mcirl.ie
Website: www.medicalcouncil.ie

IF YOU ARE CURRENTLY REGISTERED YOU CAN NOW APPLY ONLINE TO RENEW YOUR TRAINING POST. PLEASE VISIT OUR WEBSITE TO MAKE AN APPLICATION.

APPLICATION FORM FOR A NEW PERIOD OF TRAINEE SPECIALIST REGISTRATION
(USE FORM TSR2 FOR WITHDRAWAL FROM A POST.)
ALL PARTS OF THIS FORM MUST BE COMPLETED, SIGNED AND DATED.

+° SURNAME:

+°FORENAME(S):

+°ADDRESS (TO BE USED AS YOUR REGISTERED ADDRESS. YOUR CERTIFICATE WILL BE SENT TO THIS ADDRESS ONLY):

NOTE: THE REGISTRATION YEAR FOR TRAINEE SPECIALIST DOCTORS RUNS FROM 1ST JULY TO 10TH JULY EACH YEAR. IF A DOCTOR IS REGISTERED DURING THE REGISTRATION YEAR, A RETENTION FEE IS PAYABLE ON THE FOLLOWING 1ST JULY. IF REGISTRATION IS GRANTED, ITEMS MARKED + WILL APPEAR ON THE REGISTER OF MEDICAL PRACTITIONERS. IF REGISTRATION IS GRANTED, ITEMS MARKED ° MAY BE SHARED WITH RELEVANT THIRD PARTIES, EG TRAINING BODIES AND THE HSE.

°CONTACT DETAILS: (PLEASE INCLUDE INTERNATIONAL CODES IF OUTSIDE THE REPUBLIC OF IRELAND)

Phone:	
Fax:	
Mobile:	
E-mail address:	*Contacting applicants about their application by email is often quicker than by post.*

°DATE OF BIRTH: D D M M Y Y Y Y

MOTHER'S MAIDEN (BIRTH) SURNAME:

NOTE: *IN ORDER TO VERIFY YOUR IDENTITY, YOU MAY BE ASKED FOR THE ABOVE INFORMATION WHEN YOU CONTACT THE MEDICAL COUNCIL.*

A REGISTRATION YEAR MAY CONTAIN UP TO FOUR TRAINING POSTS. YOU NEED ONLY COMPLETE ONE TSR1 APPLICATION FORM PER REGISTRATION YEAR. THE START DATE OF THE FIRST TRAINING POST PER YEAR OF A TRAINING SCHEME IS NORMALLY THE 11TH OF JULY.

START DATE OF FIRST TRAINING POST THIS REGISTRATION YEAR: D D M M Y Y Y Y

IMPORTANT INFORMATION:

YOU DO NOT NEED TO PROVIDE YOUR POST NUMBER OR ADDITIONAL POST DETAILS WITH THIS APPLICATION. ALL TRAINING POST INFORMATION IS COLLATED BY THE HSE MEDICAL EDUCATION AND TRAINING UNIT ON A NATIONAL BASIS AND PROVIDED TO THE MEDICAL COUNCIL INDEPENDENTLY OF INDIVIDUAL CLINICAL SITES.

ONLY TRAINING POSTS RUN IN ACCORDANCE WITH AN APPROVED POSTGRADUATE TRAINING BODY AND PROPOSED BY THE HSE MEDICAL EDUCATION AND TRAINING UNIT CAN BE RECOGNISED BY THE MEDICAL COUNCIL AND TRAINEES DETAILS ENTERED INTO THE REGISTER. WHERE RECOGNITION BY THE HSE MEDICAL EDUCATION AND TRAINING UNIT IS NOT GRANTED THE APPLICANT CANNOT BE ENTERED IN THE TRAINEE SPECIALIST DIVISION.

PLEASE CONTACT YOUR APPROVED RECOGNISED TRAINING BODY FOR FURTHER DETAILS OF YOUR TRAINING POST.

YOUR REGISTRATION NUMBER: | | | | | | |

Form TSR1 APPLICATION FOR REGISTRATION IN AN INDIVIDUALLY NUMBERED IDENTIFIABLE TRAINING POST

IMPORTANT FEE INFORMATION:

A FEE OF €490 MUST BE PAID IN ORDER TO RETAIN A DOCTOR'S NAME ON THE REGISTER FOR THE REGISTRATION YEAR. IF YOU HAVE ALREADY PAID YOUR ANNUAL RETENTION FEE NO FEE IS REQUIRED WITH THIS APPLICATION. IF YOU ARE REGISTERING FOR THE FIRST TIME WITHIN A REGISTRATION YEAR ON OR AFTER 1ST JANUARY YOU ARE REQUIRED TO PAY A REGISTRATION FEE OF €245.

PAYMENT FORM - TO BE COMPLETED BY THE DOCTOR

Method of payment: Cheque ☐ Draft/Postal Order ☐ Credit Card ☐ Lasercard ☐

AN ADDITIONAL FEE OF 2% WILL APPLY TO ALL VISA AND MASTERCARD PAYMENTS AND €0.25 FOR ALL LASERCARD TRANSACTIONS

CREDIT CARD NUMBER																	Exp Date	M	M	Y	Y

CVV NO. (last 3 digits on back)			

☐ VISA ☐ MASTERCARD

LASERCARD NUMBER																		Exp Date	M	M	Y	Y

Name of card holder: _____

Address of card holder:

_____

_____

Annual Retention: **€490** ☐ Post begins on/after January 9th and ends before July 10th: **€245** ☐

Signature: _____ Date: _____

I hereby note and declare that:

(a) The information on this form is true and that I have signed this form in my own handwriting.
(b) I know of no reason why the Medical Council should not grant me a new period of trainee specialist registration in the Register of Medical Practitioners in accordance with the Medical Practitioners Act 2007.
(c) I acknowledge that the granting of trainee specialist registration is at the discretion of the Medical Council under the provisions of the Medical Practitioners Act 2007.
(d) I possess the linguistic capacity to communicate with patients in Ireland.
(e) I am familiar with the legislation appertaining to the practice of medicine in Ireland and have read the current edition of the Medical Council's Ethical Guide.
(f) I have not been subject to disciplinary proceedings by any Authority with which I am or have been registered as a medical practitioner.
(g) I hereby consent and give authority to the Medical Council to make any enquiry or enquiries with any body or person in pursuance of my application for a new period of trainee specialist registration.

Signature: _____ **Date:** _____