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.
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APPLICATION FORM FOR A NEW PERIOD OF TRAINEE SPECIALIST REGISTRATION

(THIS FORM IS TO BE COMPLETED FOR EACH NEW PERIOD OF TRAINEE SPECIALIST REGISTRATION. USE FORM TSR2 FOR WITHDRAWAL FROM A POST.)
ALL PARTS OF THIS FORM MUST BE COMPLETED.

SECTION A – TO BE COMPLETED BY THE DOCTOR

+ ° SURNAME:

+ °FORENAME(S):

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

***NOTE**: THE REGISTRATION YEAR RUNS FROM 1ST JULY TO 30TH JUNE 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 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.

IMPORTANT INFORMATION:

A FEE OF €490 MUST BE PAID IN ORDER TO RETAIN A DOCTOR'S NAME ON THE REGISTER FOR THE REGISTRATION YEAR. THE REGISTRATION YEAR BEGINS ON 1ST JULY AND ENDS ON 30TH JUNE. 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.

PLEASE NOTE IF YOUR NAME HAS NOT BEEN ENTERED IN THE REGISTER FOR A PERIOD OF 5 OR MORE MONTHS AND YOU ARE NOT ELIGIBLE FOR ANOTHER DIVISION OF THE REGISTER YOU ARE REQUIRED TO COMPLETE FORM TSR3.

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:** _____

Office use only	Gen Div Eligible		Category 4		TSD Only	

YOUR REGISTRATION NUMBER: | | | | | | |

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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 1st and ends before June 30th: **€245** ☐

Signature: _____ Date: _____

SECTION B - TO BE COMPLETED BY HOSPITAL ADMINISTRATION ONLY

+ ° NAME OF HOSPITAL(S) AT WHICH DR HAS BEEN OFFERED A POST. PLEASE INDICATE BASE HOSPITAL:

BASE:	
Additional clinical site(s)	

HSE AREA:

+ ° SPECIALTY IN WHICH DOCTOR WILL BE PRACTISING:	
+ ° POST TITLE:	
+ ° DATE APPOINTMENT WILL COMMENCE:	
+ ° DATE APPOINTMENT WILL TERMINATE:	
° APPROVED TRAINING POST NUMBER:	

° NAME(S) OF SUPERVISING CONSULTANT(S):

Signed: _____ Date: _____

(on behalf of hospital administration)

Name (in block capitals):

_____

Liaison Telephone No:

_____

HOSPITAL /CLINICAL SITE STAMP

MANDATORY

Office use only	Gen Div Eligible		Category 4		TSD Only	