SUPDIV2 REGISTRATION REFERENCE NUMBER:

APPLICATION FOR WITHDRAWAL FROM AN INDIVIDUALLY NUMBERED IDENTIFIABLE SUPERVISED POST

Comhairle na nDochtúi
Medical Council

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APPLICATION FORM FOR VOLUNTARY WITHDRAWAL FROM AN INDIVIDUALLY NUMBERED IDENTIFIABLE SUPERVISED POST

ALL PARTS OF THIS FORM MUST BE COMPLETED.

SECTION A – TO BE COMPLETED BY THE DOCTOR

SURNAME:

FORENAME(S):

REGISTERED ADDRESS:

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

Phone:	
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.

I WISH TO VOLUNTARILY WITHDRAW FROM THE POST DETAILED BELOW UNDER SECTION B OF THIS FORM.

Signature: _____ **Date:** _____
(To be signed by the Doctor)

SECTION B - TO BE COMPLETED BY HOSPITAL ADMINISTRATION ONLY

WITHDRAWAL FROM POST

Under S50A(9) of the MEDICAL PRACTITIONERS (AMENDMENT) ACT 2011, where a medical practitioner registered in the Supervised Division ceases to hold the post to which his or her registration relates, the employer of that practitioner shall notify the Council of that fact within 5 days of the practitioner ceasing to hold such post.

NAME OF HOSPITAL(S) FROM WHICH DR IS WITHDRAWING FROM POST:

	HOSPITAL STAMP
DATE OF WITHDRAWAL:	
POST NUMBER:	**HOSPITAL LIAISON:**
REASON FOR WITHDRAWAL:*	**TELEPHONE NO:**

*Footnote: If the reason for withdrawal relates to a concern about the doctors practice, please consider if a complaint should be made to the Medical Council.
See http://www.medicalcouncil.ie/Healthcare-Organisations/Handling-Concerns/
This document is not a complaint form and should not be used to report a concern to the Medical Council.