



MINISTRY OF FINANCE

APPLICATION AS HEALTHCARE SERVICE PROVIDER

Applicant Details

To be completed and submitted for an Application as Healthcare Service Provider for the Public Service Employees' Medical Aid Scheme ("PSEMAS").

1. Personal Details of Applicant

Surname

Given Name(s)

Country and Town of Birth

Nationality

Country of Residence

Gender (Male/Female)

Location of place of employment

If multiple, state locations

Identification Number Include a certified copy of identification

Passport Number (if applicable) Include a certified copy of passport

Visa/Permit Number (if applicable) Include a certified copy of Visa/Permit

Direct Business Telephone Number/Mobile Number

Email Address

Postal Address

Residential Address

2. Profession and qualifications

Medical Doctor (tick "✓" if applicable)

Professional Nurse (tick "✓" if applicable)

Pharmacist (tick "✓" if applicable)

Dentist (tick "✓" if applicable)

Other (specify) (tick "✓" if applicable) _____

Educational qualifications

Qualification	Year	Institution

Professional qualifications

Professional Body	Year	Status

3. Employment history for the last 10 years (start with the most recent)

3.1
Employer's Name
Type of Business
Address
Contact Number
Contact Email

Brief description of position

Start date

End date

3.2

Employer's Name

Type of Business

Address

Contact Number

Contact Email

Brief description of position

Start date

End date

3.3

Employer's Name

Type of Business

Address

Contact Number

Contact Email

Brief description of position

Start date

End date

4. Required documentary proof

	Document (Certified Copies)	Date registration terminates	✓
4.1	Proof of NAMA F Registration		
4.2	Proof of professional indemnity insurance cover		
4.3	Proof of Health Professions Council Registration		
4.4	Proof of relevant association membership		
4.5	Proof of inspection certificate from Ministry of Health and Social Services		
4.6	Proof of registration under section 22 A of the Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965) (where applicable)		
4.7	Proof of status and registration of Health Professional (e.g close corporation, company, partnership)		
4.8	Proof of contractual capacity		
4.9	Certificate of good standing from Receiver of Revenue		
4.10	Certificate of good standing from the Social Security Commission		

DECLARATION

I, the undersigned, hereby declare that:

(a) I have read the PSEMAS Terms and Conditions annexed to this application and hereby agree to abide thereby;

(b) to the best of my knowledge and belief the statements made and the information supplied in this questionnaire and the attachments are correct and that there are no other facts that are relevant to the assessment of my suitability as a healthcare practitioner;

(c) I understand that the Ministry of Finance may seek additional information from any third parties it deems necessary in view of assessing my suitability as a healthcare practitioner and I consent to their undertaking checks and searches as part of their due diligence; and

(d) I undertake to bring to the attention of the Ministry of Finance any matter which may potentially affect my status as being a healthcare service provider as and when it occurs.

APPLICANT

Print Name:	_____
Signature:	_____
Date:	__/__/____

WITNESS

Print Name:	_____
Signature:	_____
Date:	__/__/____

COMMISSIONER OF OATHS

Print Name:	_____
Signature:	_____
STAMP	

FOR OFFICE USE

Name Of Healthcare Service Provider:	_____
NAMAF No.:	_____
PSEMAS No.:	_____
ACCEPTED/DECLINED:	_____
Reasons:	_____
Printed Name	_____
Signature	_____
Date:	_____