



**SELF-EMPLOYED LOCUM STARTER FORM
(Wales Locums Only)**

All new self-employed locums working for The Well must complete this form to ensure payment can be made. A signed locum agreement must accompany the new starter form. Existing locums must use a change of details form to update their details.

**This form cannot be processed unless signed by hand and dated on page 3.
PLEASE USE BLOCK CAPTIALS AND A BLACK PEN (This ensures information is legible).**

Title	Full Registered Name	Name Known As
Address		
Postcode	Telephone No	Mobile No
Email Address		
GPhC No	Date of Original Registration	

Bank/Building Society details	Name of Bank
Address	
Sort Code ____ - ____ - ____.	Account No _____.
Account Name	Reference No (If applicable)

Own Indemnity Insurance YES/NO Policy Number _____ Insurers Name _____	Disclosure Barring Service (DBS) (Compulsory) DBS Reference Number _____ DBS Issue Date _____ Date of Birth _____
Are you registered as a Limited Company YES/NO If Yes please give details below LTD Company name:- _____ LTD Company Number:- _____ VAT Registration Number:- _____	Graduation from UK University YES/NO Do you have a permit to work in the UK? YES/NO Non UK nationals only (please provide a copy)

Please send to: Well Operations Resource Planning Department, Merchants Warehouse, Castle Street,
Manchester, M3 4LZ



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Type of Locum	Direct Locum <input type="checkbox"/>	Agency Locum <input type="checkbox"/>
Name of Agencies used:-	Distance willing to travel	Available to stay away if Hotel
Travel Arrangements	Car <input type="checkbox"/>	Public Transport <input type="checkbox"/>
Type of Bookings Taken	Forward Planned <input type="checkbox"/>	How far Ahead _____
Emergency Bookings <input type="checkbox"/>	PCO Rotas <input type="checkbox"/>	Bank Holidays <input type="checkbox"/>
Saturdays <input type="checkbox"/>	Sundays <input type="checkbox"/>	Evening Shifts <input type="checkbox"/>
If you would like to be added to our emergency texting service, please list areas covered (direct locums only)		
Rest break Availability	As per Business needs <input type="checkbox"/>	Complete Break required <input type="checkbox"/>
Break required but still available	<input type="checkbox"/>	
Religious requirements	Prayer Breaks <input type="checkbox"/>	Friday Prayers <input type="checkbox"/>
Other (including religious holidays) _____		
Other languages spoken _____		
Other languages read _____		
Any objections to selling or supplying any medicines? YES/NO		
Experience	Are you employed by any other Organisation? YES/NO	
	If yes please provide name of organisation _____	
	Number of hours you are contracted with org _____	
Do you have experience of working in Community Pharmacy? YES/NO	Do you have experience of working in a Hospital Pharmacy? YES/NO	
If yes, please give details	If yes, please give details	
_____	_____	
_____	_____	
Have you previously been employed by Well? YES/NO	Are you related to anyone who is currently employed by Well? YES/NO	
If yes, please state position, location and dates of employment	If yes, please give their name and location	
_____	_____	
_____	_____	
Are you familiar with Cegedim Pharmacy Manager? YES/NO		
Do you have any concerns about working with an Accuracy Checker? YES/NO		
If yes please state why _____		
Are you competent in the use of Methameasure? YES/NO	Regular daily workload	Less than 300 items <input type="checkbox"/>
	300-500 items <input type="checkbox"/>	more than 500 items <input type="checkbox"/>

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Minimum Accreditation Required		
MUR Accreditation (Please provide a copy) <input type="checkbox"/>	Discharge Medicine Review (DMS) (Please provide a copy) <input type="checkbox"/>	Repeat Dispensing <input type="checkbox"/>
Other Services		
Services	PCOs accredited to provide services in	Expiry Date
EHC on PGD		
EHC OTC		
Flu Vaccinations		
Minor Ailments		
Needle Exchange		
Palliative Care		
Smoking Cessation		
Supervised Consumption (including Methadone)		
Weight Management/Lipotrim		
Please list below any other services you can provide and which PCOs you are accredited to deliver them in.		
PLEASE SIGN AND DATE THIS FORM - IT CANNOT BE PROCESSED WITHOUT A SIGNATURE AND WITHOUT ALL PAGES BEING SENT THROUGH TOGETHER.		
I certify that the information provided on this form is true and accurate. I understand that I have an obligation to inform the Operations Resource Planning Department of any changes in the information I have given within 5 days of the change.		
Signature _____	Date _____	
I have double checked the bank details and confirm they are correct <input type="checkbox"/>		
FOR OFFICE USE ONLY		
Entered By	Signature	Dated

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