SELF-EMPLOYED LOCUM STARTER FORM
(England Locums Only)

All new self-employed locums working for 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_____________________________ DBS Update Service YES/NO (It is mandetory to be subscribed to the Update Service)
Valid EPS Release 2 Smart Card **(Compulsory)** Expiry Date_______________________ (please provide a copy)	Graduation from UK University YES/NO
Are you registered as a Limited Company YES/NO If Yes please give details below LTD Company name ______________________ LTD Company Number ____________________ VAT Registration Number __________________	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

SELF-EMPLOYED LOCUM STARTER FORM (cont.)
(England Locums Only)

Type of Locum Direct Locum ☐ Agency Locum ☐

Name of Agencies used:-

Distance willing to travel (miles) :- | Available to stay away if Hotel provided:- YES/NO

Travel Arrangements Car ☐ Public Transport ☐

Type of Bookings Taken Forward Planned ☐ How far Ahead ____________

Emergency Bookings ☐ PCO Rotas ☐ Bank Holidays ☐

Saturdays ☐ Sundays ☐ Evening Shifts ☐

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 ☐ Complete Break required ☐

Break required but still available ☐

Religious requirements Prayer Breaks ☐ Friday Prayers ☐

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 _________________________________
Area you're employed:

Do you have experience of working in Community Pharmacy? YES/NO
If yes, please give details
____
____

Do you have experience of working in a Hospital Pharmacy? YES/NO
If yes, please give details
____
____

Have you previously been employed by Well? YES/NO If yes, please state position, location and dates of employment
____
____

Are you related to anyone who is currently employed by Well? YES/NO 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 ☐
300-500 items ☐ more than 500 items ☐

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

SELF-EMPLOYED LOCUM STARTER FORM (cont.)
(England Locums Only)

Minimum Accreditation Required		
MUR Accreditation (Please provide a copy) ☐	NMS Accreditation (Please provide a copy) ☐	Repeat Dispensing (Please provide a copy) ☐

Other Services

Services	CCGs 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 CCGs 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 ☐

FOR OFFICE USE ONLY		
Entered By	Signature	Dated

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