



Postgraduate Medical Education and Training Board

Hercules House, Hercules Road  
London SE1 7DU  
article11@pmetb.org.uk

## Application for a statement of eligibility for registration in General Practice under Article 11 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003

**Please complete in block capital letters and black ink.  
Any illegible forms will be returned.**

### COMPLETING THIS APPLICATION FORM

#### General

This form is for applicants wishing to apply for a Statement of Eligibility for Registration in General Practice under Article 11 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003.

**To be considered by PMETB, applications must contain all of the following:**

- A fully completed application form (signed and dated);
- Proof of identification;
- Supporting evidence;
- A full and current curriculum vitae;
- A list of referees; and
- Payment of £950 (Sterling).

#### The application form, proof of identification, supporting evidence and curriculum vitae

The accompanying "Help sheet for completing the Article 11 application form" provides assistance for completing the application form and explains what proof of identification is required, what supporting evidence is required, and what should be included in a full and current curriculum vitae. You are strongly advised to read this guidance before completing and submitting your application.

#### Original documentation

All original documentation will be returned to the applicant by mail only after the decision has been issued. Please note that PMETB will not be held responsible for mail lost in the post. Authenticated documents are preferred as this reduces the risk of the applicant losing vital documents and we will not return originals part way through the process. For authentication procedures, **please see section 2(C) of the Help Sheet.**

#### Payment of your fee

All applications must be accompanied by a cheque for the required amount as indicated above, payable to "Postgraduate Medical Education and Training Board". This cheque represents the full amount of the fee that will be charged for dealing with your application. You will be liable for any charges in respect of processing your application; this amount will be deducted from your fee if you choose to withdraw your application prior to receiving a decision.

#### GMC

If your application is approved your details will be sent to the GMC when your Statement of Eligibility for Registration is issued. If you have stated in this application form that you wish your name to be included on the GP Register the GMC will automatically add your name to the GP Register, and will confirm to you in writing that it has done so. If you choose not to have your name included in the GP Register you will not be able to practise as a GP in the NHS after this date.

Please complete in block capital letters and black ink.  
Any illegible forms will be returned.

**PERSONAL DETAILS**

**YOUR PHOTOGRAPH MUST BE**

- In colour
- Passport sized
- Recent
- UK standard (see [www.passport.gov.uk](http://www.passport.gov.uk))
- Staped to this application

**Your photograph will appear on your statement of eligibility.**

**TITLE:**  Mr.  Mrs.  Miss  Ms  Dr  Prof  other \_\_\_\_\_

**FAMILY/ LAST NAME:**  
(as shown on medical diploma unless changed by marriage or Deed Poll)

**FORENAME (S):**  
(IN FULL, as shown on medical diploma unless changed by marriage or Deed Poll)

**FORMER NAME:**  
(If applicable)

**CORRESPONDENCE ADDRESS:**

**CITY:**

**POSTCODE:**

**COUNTRY:**

**DATE OF BIRTH:**     /     /      
DD MM YYYY

**MAIN CONTACT TELEPHONE NUMBER:**

**PREFERED MODE OF CONTACT:**  
 Email  
 Letter

**EMAIL:**

**COUNTRY OF CITIZENSHIP:**

**SPOUSE'S COUNTRY OF CITIZENSHIP:**

Please complete in block capital letters and black ink.  
Any illegible forms will be returned.

## 2. REGISTRATIONS

UK GENERAL MEDICAL COUNCIL REGISTRATION NUMBER:  
(if applicable)

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**(A) OTHER REGISTRATION:** (see "2 REGISTRATIONS" on the help sheet for details)

COUNTRY OF REGISTRATION:

**(B) OTHER SPECIALIST REGISTRATION:** (see "2 REGISTRATIONS" on the help sheet for details)

COUNTRY OF REGISTRATION:

**(C) CERTIFICATE OF GOOD STANDING *If applicable*** (see "2 REGISTRATIONS" on the help sheet for details)

Yes enclosed with this application form

**(D) DISCIPLINARY ACTION**

Have you ever been subject to an investigation or any disciplinary action by a medical registering body in the UK or overseas?

YES  NO

If yes, please give details.

Please complete in block capital letters and black ink.  
Any illegible forms will be returned.

### 3. QUALIFICATION (S)

Original or authenticated copies of qualifications required

#### PRIMARY MEDICAL QUALIFICATION

NAME OF QUALIFICATION:		YEAR AWARDED:	___ / ___ MM YYYY
NAME OF AWARDING UNIVERSITY:			
COUNTRY OF AWARDING UNIVERSITY:			

#### SPECIALIST POSTGRADUATE MEDICAL QUALIFICATION(S) OR OTHER RELEVANT QUALIFICATIONS

NAME OF QUALIFICATION:		YEAR AWARDED:	___ / ___ MM YYYY
NAME OF AWARDING UNIVERSITY/BODY:			
ADDRESS OF AWARDING UNIVERSITY/BODY:			
COUNTRY OF AWARDING UNIVERSITY/BODY:			

NAME OF QUALIFICATION:		YEAR AWARDED:	___ / ___ MM YYYY
NAME OF AWARDING UNIVERSITY/BODY:			
ADDRESS OF AWARDING UNIVERSITY/BODY:			
COUNTRY OF AWARDING UNIVERSITY/BODY:			

NAME OF QUALIFICATION:		YEAR AWARDED:	___ / ___ MM YYYY
NAME OF AWARDING UNIVERSITY/BODY:			
ADDRESS OF AWARDING UNIVERSITY/BODY:			
COUNTRY OF AWARDING UNIVERSITY/BODY:			

NAME OF QUALIFICATION:		YEAR AWARDED:	___ / ___ MM YYYY
NAME OF AWARDING UNIVERSITY/BODY:			
ADDRESS OF AWARDING UNIVERSITY/BODY:			
COUNTRY OF AWARDING UNIVERSITY/BODY:			

**Please complete in block capital letters and black ink.  
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**4. POSTS HELD**

Use separate sheet if needed

Please provide details of each post that you have held, stating whether these were full or part time positions (continue on separate sheet if necessary). Please list in chronological order with the most recent post first. If you have any gap(s), please include a statement explaining these gap(s) in the section entitled "5. GAPS IN TRAINING OR EXPERIENCE"

<b>START DATE</b>	<input style="width:100%;" type="text" value="___/___/___"/> <small>DD MM YYYY</small>	<b>FINISH DATE</b>	<input style="width:100%;" type="text" value="___/___/___"/> <small>DD MM YYYY</small>	<input type="checkbox"/> <b>FULL TIME</b>	<input type="checkbox"/> <b>PART TIME</b>
<b>DETAILS OF POST:</b>	<input style="width:100%; height:20px;" type="text"/>				
<b>NAME OF INSTITUTION/HOSPITAL:</b>	<input style="width:100%; height:20px;" type="text"/>				
<b>NAME OF SUPERVISOR:</b> <small>(if applicable)</small>	<input style="width:100%; height:20px;" type="text"/>				
<b>SPECIALTY:</b>	<input style="width:100%; height:20px;" type="text"/>				

<b>START DATE</b>	<input style="width:100%;" type="text" value="___/___/___"/> <small>DD MM YYYY</small>	<b>FINISH DATE</b>	<input style="width:100%;" type="text" value="___/___/___"/> <small>DD MM YYYY</small>	<input type="checkbox"/> <b>FULL TIME</b>	<input type="checkbox"/> <b>PART TIME</b>
<b>DETAILS OF POST:</b>	<input style="width:100%; height:20px;" type="text"/>				
<b>NAME OF INSTITUTION/HOSPITAL:</b>	<input style="width:100%; height:20px;" type="text"/>				
<b>NAME OF SUPERVISOR:</b> <small>(if applicable)</small>	<input style="width:100%; height:20px;" type="text"/>				
<b>SPECIALTY:</b>	<input style="width:100%; height:20px;" type="text"/>				

<b>START DATE</b>	<input style="width:100%;" type="text" value="___/___/___"/> <small>DD MM YYYY</small>	<b>FINISH DATE</b>	<input style="width:100%;" type="text" value="___/___/___"/> <small>DD MM YYYY</small>	<input type="checkbox"/> <b>FULL TIME</b>	<input type="checkbox"/> <b>PART TIME</b>
<b>DETAILS OF POST:</b>	<input style="width:100%; height:20px;" type="text"/>				
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<b>NAME OF SUPERVISOR:</b> <small>(if applicable)</small>	<input style="width:100%; height:20px;" type="text"/>				
<b>SPECIALTY:</b>	<input style="width:100%; height:20px;" type="text"/>				

<b>START DATE</b>	<input style="width:100%;" type="text" value="___/___/___"/> <small>DD MM YYYY</small>	<b>FINISH DATE</b>	<input style="width:100%;" type="text" value="___/___/___"/> <small>DD MM YYYY</small>	<input type="checkbox"/> <b>FULL TIME</b>	<input type="checkbox"/> <b>PART TIME</b>
<b>DETAILS OF POST:</b>	<input style="width:100%; height:20px;" type="text"/>				
<b>NAME OF INSTITUTION/HOSPITAL:</b>	<input style="width:100%; height:20px;" type="text"/>				
<b>NAME OF SUPERVISOR:</b> <small>(if applicable)</small>	<input style="width:100%; height:20px;" type="text"/>				
<b>SPECIALTY:</b>	<input style="width:100%; height:20px;" type="text"/>				

Please complete in block capital letters and black ink.  
Any illegible forms will be returned.

#### 4. POSTS HELD ...cont

Use separate sheet if needed

Please list in chronological order with the most recent post first.

START DATE	<input type="text" value="DD / MM / YYYY"/>	FINISH DATE	<input type="text" value="DD / MM / YYYY"/>	<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME
DETAILS OF POST:	<input type="text"/>				
NAME OF INSTITUTION/HOSPITAL:	<input type="text"/>				
NAME OF SUPERVISOR: (if applicable)	<input type="text"/>				
SPECIALTY:	<input type="text"/>				

START DATE	<input type="text" value="DD / MM / YYYY"/>	FINISH DATE	<input type="text" value="DD / MM / YYYY"/>	<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME
DETAILS OF POST:	<input type="text"/>				
NAME OF INSTITUTION/HOSPITAL:	<input type="text"/>				
NAME OF SUPERVISOR: (if applicable)	<input type="text"/>				
SPECIALTY:	<input type="text"/>				

START DATE	<input type="text" value="DD / MM / YYYY"/>	FINISH DATE	<input type="text" value="DD / MM / YYYY"/>	<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME
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START DATE	<input type="text" value="DD / MM / YYYY"/>	FINISH DATE	<input type="text" value="DD / MM / YYYY"/>	<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME
DETAILS OF POST:	<input type="text"/>				
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NAME OF SUPERVISOR: (if applicable)	<input type="text"/>				
SPECIALTY:	<input type="text"/>				

Please complete in block capital letters and black ink.  
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#### 4. POSTS HELD ...cont

Use separate sheet if needed

Please list in chronological order with the most recent post first.

START DATE	<input type="text" value="___/___/___"/> DD MM YYYY	FINISH DATE	<input type="text" value="___/___/___"/> DD MM YYYY	<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME
DETAILS OF POST:	<input type="text"/>				
NAME OF INSTITUTION/HOSPITAL:	<input type="text"/>				
NAME OF SUPERVISOR: (if applicable)	<input type="text"/>				
SPECIALTY:	<input type="text"/>				

START DATE	<input type="text" value="___/___/___"/> DD MM YYYY	FINISH DATE	<input type="text" value="___/___/___"/> DD MM YYYY	<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME
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NAME OF SUPERVISOR: (if applicable)	<input type="text"/>				
SPECIALTY:	<input type="text"/>				

START DATE	<input type="text" value="___/___/___"/> DD MM YYYY	FINISH DATE	<input type="text" value="___/___/___"/> DD MM YYYY	<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME
DETAILS OF POST:	<input type="text"/>				
NAME OF INSTITUTION/HOSPITAL:	<input type="text"/>				
NAME OF SUPERVISOR: (if applicable)	<input type="text"/>				
SPECIALTY:	<input type="text"/>				

START DATE	<input type="text" value="___/___/___"/> DD MM YYYY	FINISH DATE	<input type="text" value="___/___/___"/> DD MM YYYY	<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME
DETAILS OF POST:	<input type="text"/>				
NAME OF INSTITUTION/HOSPITAL:	<input type="text"/>				
NAME OF SUPERVISOR: (if applicable)	<input type="text"/>				
SPECIALTY:	<input type="text"/>				

**Please complete in block capital letters and black ink.  
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## 5. GAPS IN TRAINING OR EXPERIENCE

Use separate sheet if needed

Please list any periods when you were not employed or contracted in a medical post during the period covered by the posts you have listed in Section 4 **POSTS HELD**, and add a brief explanation of each gap listed (if applicable).

## ORDER OF EVIDENCE GUIDE

This chart has been provided in order to show the types of reoccurring evidence under each Good Medical Practice heading. These are taken from the generic guidance relevant to all specialties to assist you with providing a wide range of evidence. You will need to refer to the General Practice Specialty Specific Guidance to provide further documentary evidence.

PRESENTING YOUR APPLICATION TO PMETB	GMP1	GMP 2	GMP 3	GMP 4	GMP5	GMP 6
1. Application Form						
2. Curriculum Vitae	✓	✓	✓	✓	✓	✓
3. Proof of identity						
4. Registrations						
5. Qualifications	✓					
6. Training	✓					
7. Evidence and details of posts and duties	✓					
8. Logbooks and or records of daily clinical practice	✓	✓	✓			✓
9. Assessments and appraisals on the applicant	✓	✓	✓	✓	✓	✓
10. Teaching, training, appraising and assessing			✓	✓	✓	✓
11. Relationships with patients		✓				✓
12. Working with Colleagues					✓	✓
13. Participation in departmental audit, service improvement, directorate and management meetings			✓	✓	✓	
14. CPD and relevant courses and conferences	✓	✓	✓	✓		
15. Research, publications and presentations			✓			

**Please complete in block capital letters and black ink.  
Any illegible forms will be returned.**

## 6. EVIDENCE SUBMITTED IN SUPPORT OF YOUR APPLICATION

Validated copies of evidence required

Please list all the documentary evidence you are providing in support of your application under each heading below. You will need to refer to the General Practice Specialty Specific Guidance for your specialty (available on the PMETB website [www.pmetb.org.uk](http://www.pmetb.org.uk)) to see what evidence is suggested for inclusion with your application. If you are unable to provide any evidence under any of the headings provided please provide a brief explanation.

### 1. Application form:

- fully completed in each section and evidence has been provided to support each section

### 3. Identity:

- This includes a colour photocopy of your current passport or Identity card and a coloured passport photo.

### 2. Curriculum Vitae:

- up to date and in chronological order

### 4. Registrations:

- Please provide authenticated copies of your current registration including any overseas registrations and certificate of good standing

### 5. Qualifications

- Authenticated copy of your PMQ certificate - compulsory
- Certificates of Specialist Postgraduate Medical Qualifications or other relevant Qualifications/ examinations e.g. College/Faculty exams. If you have overseas qualifications submit original or authenticated qualification and the examination syllabi.

**Please list your documentary evidence in the box provided below.**

### 6. Training - for example

- Evidence of training posts and course/programme followed e.g. a curriculum or validated details of the programme of training
- Training logbooks/portfolios, training assessments/appraisals forms (logbooks must not include patient names)
- Evidence that training was recognised by relevant authorities

**Please list your documentary evidence in the box provided below.**

### 7. Evidence and details of posts and duties – for example

- Validated employment record of each post with validated details including type of post, description of duties, number of cases and case mix
- Letters of employment, validated job descriptions and contracts of employment
- On-call rota details job plan/work programme and annual caseloads from last 5 years of practice
- Detailed job description for each post listed chronologically in your CV
- Revalidation/appraisal portfolios

**Please list your documentary evidence in the box provided below.**

**Please complete in block capital letters and black ink.  
Any illegible forms will be returned.**

**6. EVIDENCE SUBMITTED IN SUPPORT OF YOUR APPLICATION cont ....**

Validated copies of evidence required

**8. Logbooks and or records of daily clinical practice for the last five years**

- Validated and signed by the relevant hospital on each individual pages – do not include individual patient names
- Covering the last five years showing the type of procedures performed, whether supervised, assisted or unassisted and that these were performed by the applicant.
- Consolidated sheets for each logbook.

**Please list your documentary evidence in the box provided below.**

**9. Assessments and appraisals – for example**

- Workplace-based assessments, formal assessments / appraisals for the last 5 years
- 360 degree feedback
- RITA Forms from UK training.

**Please list your documentary evidence in the box provided below.**

**10. Teaching, training, appraising and assessing – for example**

- Participation in teaching, lecturing, and management over last 5 years supported by letter confirming role e.g. from Postgraduate Dean or academic head of department
- Evidence of attendance at relevant courses
- Feedback from students

**Please list your documentary evidence in the box provided below.**

**11. Relationships with patients**

- Evidence / letters from specific cases (anonymised – please do not include patients names as this contravenes data protection requirements and cannot be submitted as evidence)
- Evidence of training and/or course in communication skills, patient consent
- Multi-source feedback (including feedback from patients or their families) or external or peer-review reports.

**Please list your documentary evidence in the box provided below.**

**Please complete in block capital letters and black ink.  
Any illegible forms will be returned.**

**6. EVIDENCE SUBMITTED IN SUPPORT OF YOUR APPLICATION cont ....**

Validated copies of evidence required

**12. Working with Colleagues**

- Structured reports from supervisors and colleagues (nominated referees)
- Participation in management activities e.g. developing, delivering and managing high quality services including staff management supported by evidence from clinical director or equivalent
- Participation in multidisciplinary or clinical meetings
- Letters of appreciation from colleagues

**Please list your documentary evidence in the box provided below.**

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**13. Participation in departmental audit, service improvement, directorate and management meetings**

- Evidence of the different types of meeting attended for the last five years front page only
- Must show your name and that of the hospital
- Must be stamped by the relevant hospital and signed by someone who can attest to the event.
- Evidence of departmental audits carried out – validated

**Please list your documentary evidence in the box provided below.**

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**14. Continuing professional development or medical education**

- College or Hospital CPD registration letters, CPD certificates for the last five years or equivalent for overseas doctors
- Attendance at national/international conferences
- Membership of professional bodies and organisations (supported by evidence of membership certificates)

**Please list your documentary evidence in the box provided below.**

--

**15. Research, publications and presentations**

- Front page only of each publication for the last five years
- All evidence presented that has does not show evidence of publication must be validated by the hospital and signed by someone who can attest to this as true and factual

**Please list your documentary evidence in the box provided below.**

--

Please complete in block capital letters and black ink.  
Any illegible forms will be returned.

## 7. REFEREE LIST

Please refer to **section 7** of the **Help Sheet**, for assistance in filling out this section of the form.

### 1ST REFEREE (Must be your current Medical Director, Clinical Director or equivalent level e.g. Superintendent if overseas)

TITLE:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> other _____		
FORENAME (S):		SURNAME:	
JOB TITLE			
INSTITUTION			
POSTAL ADDRESS:			
POSTCODE		TELEPHONE NUMBER:	
EMAIL ADDRESS			

### 2ND REFEREE

TITLE:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> other _____		
FORENAME (S):		SURNAME:	
JOB TITLE			
INSTITUTION			
POSTAL ADDRESS:			
POSTCODE		TELEPHONE NUMBER:	
EMAIL ADDRESS			

Please complete in block capital letters and black ink.  
Any illegible forms will be returned.

## 7. REFEREE LIST ....cont

### 3RD REFEREE

TITLE:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> other _____	
FORENAME (S):	<input type="text"/>	SURNAME: <input type="text"/>
JOB TITLE	<input type="text"/>	
INSTITUTION	<input type="text"/>	
POSTAL ADDRESS:	<input type="text"/>	
	<input type="text"/>	
POSTCODE	<input type="text"/>	TELEPHONE NUMBER: <input type="text"/>
	<input type="text"/>	
EMAIL ADDRESS	<input type="text"/>	

### 4TH REFEREE

TITLE:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> other _____	
FORENAME (S):	<input type="text"/>	SURNAME: <input type="text"/>
JOB TITLE	<input type="text"/>	
INSTITUTION	<input type="text"/>	
POSTAL ADDRESS:	<input type="text"/>	
	<input type="text"/>	
POSTCODE	<input type="text"/>	TELEPHONE NUMBER: <input type="text"/>
	<input type="text"/>	
EMAIL ADDRESS	<input type="text"/>	

Please complete in block capital letters and black ink.  
Any illegible forms will be returned.

## 7. REFEREE LIST ....cont

### 5TH REFEREE

TITLE:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> other _____	
FORENAME (S):	<input type="text"/>	SURNAME: <input type="text"/>
JOB TITLE	<input type="text"/>	
INSTITUTION	<input type="text"/>	
POSTAL ADDRESS:	<input type="text"/>	
	<input type="text"/>	
POSTCODE	<input type="text"/>	TELEPHONE NUMBER: <input type="text"/>
	<input type="text"/>	
EMAIL ADDRESS	<input type="text"/>	

### PLEASE PROVIDE A 6TH REFEREE IN THE EVENT ONE OF THE ABOVE REFEREES DOES NOT PROVIDE A REFERENCE

TITLE:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> other _____	
FORENAME (S):	<input type="text"/>	SURNAME: <input type="text"/>
JOB TITLE	<input type="text"/>	
INSTITUTION	<input type="text"/>	
POSTAL ADDRESS:	<input type="text"/>	
	<input type="text"/>	
POSTCODE	<input type="text"/>	TELEPHONE NUMBER: <input type="text"/>
	<input type="text"/>	
EMAIL ADDRESS	<input type="text"/>	

**Please complete in block capital letters and black ink.  
Any illegible forms will be returned.**

## 8. SIGNATURE AND DECLARATION

I confirm that the information given on this form is true, complete and accurate and no information requested or other relevant information has been omitted.

I understand that my application to PMETB may be adversely affected if any information or documentation requested is not correct or is omitted. I have also included details of any investigation and or disciplinary action taken against me by a medical registering body.

I understand that any serious misrepresentation supplied with the intention to mislead may be reported to the GMC or my current registering body.

I agree that PMETB may seek any further information which it considers is relevant to my application for a Statement of Eligibility for Registration, and that my personal details may be made available to a third party(ies), as required, for the purposes of evaluating my General Practise training, qualifications and experience.

I enclose a cheque for the required amount, payable to **Postgraduate Medical Education and Training Board**, which represents the full amount of the fee that will be charged for dealing with my application. I understand that I will be liable for any charges in respect of processing this application and that this amount will be deducted from my fee, if I choose to withdraw my application.

I understand that if I do not provide all the information with full supporting documentation required together with a fully completed application form, PMETB will be unable to proceed with my application and my application together with the payment will be returned to me.

I also understand that before my application will be considered complete, PMETB may request additional documentation and all structured reports from my nominated referees must have been received.

I have submitted the following information and documentation, with my signed and completed application form (including the checklist).

### Check list (you must provide the following):

- a) Application form completed, signed and dated
- b) Passport sized photograph stapled to this form.
- c) Proof of identity.
- d) Certificate of Good Standing, if not registered with the GMC
- e) Original or authenticated evidence
- f) A completed list of Referees
- g) A full and current Curriculum Vitae
- h) A cheque for £950 (Sterling), payable to **Postgraduate Medical Education and Training Board**.

Please return your application form and required documentation as outlined in the checklist to:  
Article 11 Application  
PMETB  
Hercules House, Hercules Road  
London SE1 7DU

You may contact PMETB on 0871 220 3070 or (+44) 0207 160 6187

**Email:** [article11@pmetb.org.uk](mailto:article11@pmetb.org.uk)

**Website:** [www.pmetb.org.uk](http://www.pmetb.org.uk)

Your name must be included in the GP Register if you wish to practise as a GP in the NHS. Please indicate below if you would like your name to be included in the GP Register if your application is successful.

I apply to the Registrar of the GMC to include my name in the General Practice Register.

YES  NO

**I understand that if my application is incomplete, there may be a significant delay before it can be considered.**

SIGNATURE: \_\_\_\_\_

DATE:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

**Please print your full name (title, first name and surname) in block letters below**

Name: \_\_\_\_\_