



**MEDICAL INDEMNITY REGISTER**  
**PO BOX 44375**  
**LONDON SW19 8WA**



TEL: (44) (0)20 8739 0066 E-mail: malpractice@btconnect.com Web: www.medicalindemnity.com FAX: (44) (0)20 8739 0077

**INDIVIDUAL 'SAMARITAN ACT' ONLY APPLICATION FORM**

Please note that only persons with the minimum qualification of first aider or appointed person may be accepted for membership. Doctors, nurses, paramedics, EMTs etc. are all also welcome.

Malpractice insurance issued by the Medical Indemnity Register is only valid for cases heard under United Kingdom and Channel Islands jurisdiction - unless special cover has been arranged. Cases in respect of treatments carried out on United States of America or Canadian territory cannot be covered.

**For all activities outside of the Good Samaritan Act (please see overleaf) please complete a proposal form available from our web site or by calling us.**

(PLEASE PRINT)

(01/10/07)

FULL NAME		(Dr/Nurse/Mr/Mrs/Miss/Ms)	
ADDRESS			
TOWN			
COUNTY		POST CODE	
TEL:		HOW DID YOU HEAR OF US?	

QUALIFICATION:		DATE ISSUED:	
ISSUING BODY:		DATE EXPIRES:	
LEVEL OF COVER REQUIRED?	£250k	£1M	£2M
			£5M
1 INSTRUCTOR/TEACHER COVER? - PLEASE GO TO OUR WEB SITE AND DOWNLOAD A PROPOSAL FORM			
NB: This form is not applicable if you offer your services to any outside company, individual or organisation.			

Have any claims or suits alleging negligence, error or omission been made against yourself or are there any circumstances of which you may be aware, which may give rise to a claim?	
Please answer 'yes' or 'no'	If the answer is yes, please give full details on a separate sheet.

I hereby declare and warrant that the above statements and particulars are in all respects complete and true, that they are material and I have not suppressed or mis-stated any material facts and I agree that this shall be the basis of the contract with underwriters and deemed part of the insurance coverage issued to me.

SIGNATURE OF APPLICANT	This form <u>must</u> be signed by the applicant.
DATE OF APPLICATION:	

**IF SUBSCRIPTION IS BEING PAID BY AN EMPLOYER, PLEASE COMPLETE BELOW**

**NB: THIS COVER DOES NOT INDEMNIFY THE COMPANY WHO IS PAYING FOR THIS MEMBERSHIP**

CONTACT NAME		(Dr/Nurse/Mr/Mrs/Miss/Ms)	
POSITION			
COMPANY NAME			
ADDRESS			
TOWN			
COUNTY		POST CODE	
TELEPHONE:		FAX OR E-MAIL:	
SIGNATURE:		DATE AUTHORISED:	

OFFICE USE ONLY			
QUALIFICATION(S) VERIFIED		COVER COMMENCES	1st
LIMIT OF COVER		ENTERED ON REGISTER	
PAYMENT METHOD/AMOUNT		NEW MEMBER PACK SENT	

