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Healthcare Inspectorate Wales

(HIW)

Change of Responsible Individual (RI) information

**Background**

Please read the document “Guidance - information to be supplied when Responsible Individuals (RIs) change” before completing this application form.

It is the responsibility of the registered provider to assure HIW that they have appointed a new RI who meets the fitness requirements.

It is also the responsibility of the registered provider or duly authorised director or company secretary (whichever is appropriate), to ensure this form is completed and returned to HIW. By completing this form you are providing assurance to HIW that you are meeting the requisite regulatory requirements in respect of your new RI.

**Filling in this form**

You must provide an answer to all questions. You must also complete the declaration of compliance at Section 3.

|  |  |
| --- | --- |
| **Details of registered provider**  | Name:  |
| Address:  |
| Postcode:  |
| Telephone:  |

|  |
| --- |
| **Mailing and contact details - Personal correspondence address of the RI** |
| Full Name of Individual: |
| Property name: |
| Number/street:  |
| District/town/city: |
| County / Postcode: |
| Telephone: |
| Mobile: |
| E-mail:  |
| **Mailing and contact details - Business address of the RI** |
| Property name:  |
| Number/street:  |
| District/town/city:  |
| County / Postcode:  |
| Telephone:  |
| Mobile:  |
| Fax:  |
| E-mail:  |

|  |
| --- |
| 1. **Details of any current and previously registered establishments**
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| 1. Has the RI owned or managed any current or previously registered establishments?

 YES [ ]  NO [ ]  |
| ***If YES, please provide the following details for each relevant establishment or agency:*** Date of registration: Registration certificate number: Name of Commission (e.g. CSSIW): Name of establishment or agency: Address: Postcode: Registration categories/type of service:  |
| 1. Has the RI ever had an application to register under the above legislation (or the Registered Homes Act 1984) **refused**, or had an existing registration **cancelled**?

 YES [ ]  NO [ ]  |
| ***If you answered YES to the above, please provide details on a separate sheet.***  |
| 1. Is the RI currently registered with HIW as a provider or manager of independent healthcare?

 YES [ ]  NO [ ]  |
| 1. **Supporting information**
 |
| 1. Please confirm that you have a comprehensive CV for the RI which includes:
* date of birth
* address and postcode
* contact telephone numbers
* current and previous employment details, which must include the name and address of employers together with a description of job title, responsibilities, reasons for leaving and explanations of any gaps in employment history
* details of any professional or technical qualifications held, including copies of certificates

 YES [ ]  NO [ ]  (If no please state why) |
| 1. Please confirm that you also have the following information available:
* details of any disciplinary action taken against the RI at any stage of their career
* if a healthcare professional, please include their registration number for the professional body together with the expiry date
* the names and addresses, including postcode, of two referees - who are not related to the RI; one of whom has employed them for a period of at least three months and one of whom is their most recent former employer.

 YES [ ]  NO [ ]  (If no, please state why)  |
| 1. Please confirm that written references have been provided to you that demonstrate the RI is competent to supervise the management of establishments operated by the organisation.

  YES [ ]  NO [ ]  (If no, please state why) |
| 1. Please provide a copy of the job description for the RI
 |
| 1. Please confirm that you have all of the information in respect of the RI as required by Schedule 2 of the Independent Health Care (Wales) Regulations 2011.

 YES [ ]  NO [ ]  (If No please give details) |
| 1. Has an appropriate Disclosure and Barring Service (DBS) check been undertaken for the RI?

 YES ⬜ NO ⬜ (Please tick)**If you have answered ‘YES’ to please state:**Date of issue ……………………………………………Unique reference number …………………………….……………. |
| **3. Declaration** |
| By signing this declaration, you are confirming you are satisfied that:* the new RI meets the fitness requirements of the Independent Health Care (Wales) Regulations 2011
* the new RI has been provided with a signed copy of this form

 * you meet and will continue to meet the obligations under the Independent Health Care (Wales) Regulations 2011

This declaration must be signed by a registered provider, (duly authorised director or company secretary, whichever is appropriate). I hereby declare that the information detailed in this form is true and accurate and has been checked against the records held by us. I have taken a copy of all the documentation submitted for our records.  |
| Signed: (duly authorised) |  |
| Print name:  |  |
| Position in organisation (where appropriate): |  |
| Date sent:  |  |

Please return the completed application form and Responsible Individual’s job description to**:**

Regulation Team

**Healthcare Inspectorate Wales**
Government Buildings
Rhydycar Business Park
Merthyr Tydfil CF48 1UZ

hiwregistration@gov.wales