## AGIC Arolygiaeth Gofal Iechyd Cymru HIW Healthcare Inspectorate WalesSecond Opinion Appointed Doctor

## (SOAD) Wales Application Form

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| **Once complete, please send via email to HIW.RSMH@gov.wales along with the following:**   * a completed proforma. * a current CV. * a letter of support from your current employer (supporting your application and acknowledging that there will be flexibility for you to undertake visits during the working week)   **CLOSING DATE FOR APPLICATIONS**: **30th April 2025** |

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|  | **How did you hear about this vacancy?** | |  |
|  | Please provide details here: |  |  |
| **What is your preferred language for communicating with HIW?**  (e.g. verbally or in writing) – place an x in the box.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Welsh** |  | **English** |  | **Welsh and English** |  | | | | |

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| **Personal Data**  Your privacy is important to the Healthcare Inspectorate Wales as part of the Welsh Government and in line with General Data Protection Regulations (GDPR) we have developed a Privacy Notice that covers why we collect and use your information.  Our Privacy Notice can be found at: <http://hiw.org.uk/terms_and_conditions/privacynotice/> |

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|  | | Part 1: Your personal detailsPlease complete in block capitals | | | | | | | |  | |
|  | | Title: | Dr / Prof / Other (please specify) | | | | | |  | | |
| Forename(s): |  | | | | | |
| Surname: |  | | | | | |
| Address: |  | | | | | |
| Postcode: |  | | | | | |
| Contact number(s) |  | | | | | |
| Email address: |  | | | | | |
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|  | Could you conduct an interview with a patient in Welsh? | | YES |  | NO |  |  | | |
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|  | Could you conduct an interview with a patient in any language other than English? If yes, please specify in the box below. | | YES |  | NO |  |  | | |
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|  | Have you received any criminal convictions or police cautions at any time? | YES |  | NO |  |  |
|  | **The post of SOAD is exempt from the Rehabilitation of Offenders Act** | | | | | |
| If Yes, please provide details below | | | | | | |
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|  | | Part 2: Qualifications and professional registration | | | | | | | |  |
| Primary professional qualification |  | | | | | | |
| Year of qualification and awarding university: |  | | | | | | |
| RCPsych qualification: | MRCPsych |  | FRCPsych | | |  | |
| Other equivalent specialist psychiatric qualification for entry to specialist register:  (Please specify including country of origin) |  | | | | | | |
| GMC registration No: |  | | | | | | |
| Revalidation date: |  | | | | | | |
| RCPsych membership No: |  | | | | | | |
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| GMC Specialist Registration (please specify the register(s) in which your name appears) | | | | | | | |
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|  | Are you registered for CPD with RCPsych ? | | | YES |  | NO | |  |  |
|  | If the answer to the above question is “NO” which professional body are you registered with and what is your registration number? | | | | | | | |  |
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|  | Are you in good standing with your registration for CPD with your professional body? | | | YES |  | NO | |  |  |
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|  | Relevant Clinical Experience Please tick where appropriate and detail on your CV | | | |  |
|  | Adult Mental Health |  | Older Persons Mental Health |  |  |
|  | Forensic Mental Health |  | Child & Adolescent Mental Health |  |  |
|  | Learning Disabilities |  |  |  |  |
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|  | Have you been subject to any complaints that are being investigated or have been investigated (local, GMC, NCAS or other) and are not yet resolved? | YES |  | NO |  |  |
|  | If yes, please provide details | | | | |  |
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|  | Have any of the above investigations of complaints resulted in action e.g. constraints on clinical practice or retraining? | YES |  | NO |  |  |
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|  | Have you addressed any complaints in your last appraisal? | YES |  | NO |  |  |
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|  | If no, will you be addressing them in your next appraisal? | YES |  | NO |  |  |
|  | | | | | | |
|  | Has your registration with the GMC, or other professional regulatory body, ever been suspended or subject to conditions? | YES |  | NO |  |  |
|  | If yes, please provide timing and details in the box below | | | | |  |
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|  | Part 3: SOAD roleAre there any areas of clinical practice which you would not feel competent to express an opinion as a SOAD? Please tick where appropriate | | | |  |
|  | Adult Mental Health |  | Older Persons Mental Health |  |  |
|  | Forensic Mental Health |  | Child & Adolescent Mental Health |  |  |
|  | Learning Disabilities |  |  |  |  |
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|  | Please list any hospitals within a reasonable travelling distance of your home or work which you might not be able to visit as a SOAD due to a conflict of interest (please see advice on conflict of interest in the SOAD specification document) | |  |
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|  | Are you able to commit to a minimum of 30 SOAD visits per year in your role as a SOAD? | YES |  | NO |  |  |
|  | If no, what are your reasons why and how many do you believe you can commit to? | | | | |  |
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|  | SOAD activity will include travel to hospitals or sites within a reasonable geographical travelling distance of your work or home and attendance at training events. On this basis: | | | | |  |
|  | Do you have a current driving licence? | YES |  | NO |  |  |
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|  | Do you foresee any problems with travel? | YES |  | NO |  |  |
|  | If yes, please give details | | | | |  |
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|  | Would you be willing to attend SOAD “clinics” where patients who are subject to a Community Treatment Order are scheduled to attend by the provider | YES |  | NO |  |  |
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|  | Part 4: References Please provide the names and addresses of two professional referees – one of whom should be the Medical Director, Chief Executive of your current or last employing authority or a doctor who is in a managerial position with you or the individual who was your last appraiser. | | |  |
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|  | Name: |  | Name: |  |
|  | Job title: |  | Job title: |  |
|  | Address: |  | Address: |  |
|  | Postcode: |  | Postcode: |  |
|  | Telephone No: |  | Telephone No: |  |
|  | Email: |  | Email: |  |
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|  | Declaration I confirm that to the best of my knowledge and belief, the information given is complete and correct. I understand that if I am appointed and if the information I have provided is incorrect, or any of the statements made in this declaration are untrue or subsequently circumstances arise at any time which would render any such statements untrue, then my tenure as a SOAD may be terminated. | |  |
|  | **Signature:** |  |  |
| **Date:** |  |
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