challenge

Specialist Practitioner Application Form

IMPORTANT INFORMATION – PLEASE READ

This Application Form, which is designed for practitioners on the Medical Council specialist register, must be signed by the Applicant.

It is the duty of the Applicant to disclose all material facts. For the purpose of this Application Form, a material fact shall be deemed to be one that would be likely to influence the judgement of a prudent insurer in fixing the premium or determining whether to underwrite the risk.

Each section of this Application Form must be completed in full. Incomplete or unsigned forms will not be accepted.

Should there be insufficient room on any part of the Application Form to record all necessary details, please use the space provided in Section 5 with reference to the appropriate question.

Failure to disclose full and accurate details may entitle Insurers to void your contract of insurance and will mean that you are not entitled to any benefits of, nor make any claims against, your policy.

It is the responsibility of the Applicant to notify any future change of address or any changes in their professional circumstances.

Once completed, please sign and date the Declaration in Section 6 and return it to:

Challenge Insurance Brokers Limited
Challenge House, Unit 11 Burnell Square, Mayne River Way, Malahide Road, D17 VY04.

Email: insurance@challenge.ie
Tel: +353 1 8395942

Should you have any questions, please contact Challenge Insurance Brokers Limited on +353 1 8395942

THE SIGNING OF THIS APPLICATION FORM DOES NOT BIND THE APPLICANT, OR INSURERS, TO COMPLETE A CONTRACT OF INSURANCE.

Section 1 – Basic Details

1. Title: Select

2. Forename:

3. Surname:

4. Date of Birth: Day Month 2010

5. Residential Address (for all correspondence):

6. Email Address:

7. Mobile No.:

8. Practice Address:

9. IMC Specialist Registration No.:
Refer if no valid IMC registration

10. IMC Registration Type: Please Select

Section 2 – Practice Profile

12. Please indicate your specialty

- ABDOMINAL SURGERY ☐
- ADMINISTRATIVE MEDICINE ☐
- ANAESTHESIOLOGY ☐
- ANGIOGRAPHY, ARTERIOGRAPHY & CATHETERIZATION ☐
- BARIATRIC SURGERY ☐
- BRONCO - ESOPHAGOLOGY ☐
- CARDIAC SURGERY ☐
- CARDIOVASCULAR DISEASE (NO SURGERY) ☐
- CARDIOVASCULAR DISEASE (SURGERY) ☐
- COLON AND RECTAL SURGERY ☐
- COLONOSCOPY, ERCP & ESOPHAGEAL DILATION ☐
- DERMATOLOGY (NO SURGERY) ☐
- DERMATOLOGY (SURGERY) ☐
- DIABETES (NO SURGERY) ☐
- DISCOGRAMS, MYELOGRAPHY & PNEUMOENCEPH ☐
- EAR NOSE AND THROAT (NO SURGERY) ☐
- EAR NOSE AND THROAT (SURGERY) ☐
- EMERGENCY MEDICINE (NO MAJOR SURGERY) ☐
- EMERGENCY MEDICINE/TRAUMA (INCLUDES MAJOR SURGERY) ☐
- ENDOCRINOLOGY ☐
- FAMILY/GENERAL PRACTICE (NO SURGERY) ☐
- FAMILY/GENERAL PRACTICE (SURGERY) ☐
- FORENSIC OR LEGAL MEDICINE ☐
- GASTROENTEROLOGY (NO SURGERY) ☐
- GASTROENTEROLOGY (SURGERY) ☐
- GENERAL PREVENTIVE MEDICINE ☐
- GENERAL SURGERY (EXCLUDING BARIATRIC) ☐
- GERIATRICS (NO SURGERY) ☐
- GYNAECOLOGY (NO SURGERY) ☐
- GYNAECOLOGY (SURGERY) ☐
- HAND SURGERY ☐
- HEAD AND NECK SURGERY ☐
- HAEMATOLOGY (NO SURGERY) ☐
- HOSPITALISTS ☐
- IMMUNOLOGY ☐
- INFECTIOUS DISEASE ☐
- INTENSIVE CARE MEDICINE ☐
- INTERNAL MEDICINE (NO SURGERY) ☐
- LUMPHANGIOGRAPHY & PHLEBOGRAPHY ☐
- MAXILOFACIAL SURGERY ☐
- NEEDLE BIOPSY ☐
- NEONATOLOGY (CRITICAL CARE) ☐
- NEONATOLOGY (NON-CRITICAL CARE) ☐
- NEOPLASTIC DISEASES (NO SURGERY) ☐
- NEOPLASTIC DISEASES/ONCOLOGY SURGERY ☐
- NEPHROLOGY ☐
- NEUROLOGY (NO SURGERY) ☐
- NEUROLOGY (SURGERY) ☐
- NUCLEAR MEDICINE ☐
- NUTRITIONIST ☐
- OCCUPATIONAL MEDICINE ☐
- ONCOLOGY (NO SURGERY) ☐
- OPHTHALMOLOGY ☐
- ORTHOPAEDIC SURGERY (EXCLUDING SPINE) ☐
- ORTHOPAEDIC SURGERY (INCLUDING SPINE) ☐
- PATHOLOGY ALL OTHER ☐
- PATHOLOGY CYTOPATHOLOGY ☐
- PAEDIATRICS (NO SURGERY) ☐
- PAEDIATRICS (SURGERY) ☐
- PERINATOLOGY ☐
- PHARMACOLOGY ☐
- PHYSICAL MEDICINE AND REHABILITATION ☐
- PHYSICIANS OR SURGEONS ASSISTANTS ☐
- PLASTIC SURGERY ☐
- PODIATRISTS (ABOVE THE ANKLE) ☐
- PODIATRISTS (BELOW THE ANKLE) ☐
- PSYCHIATRY ☐
- PUBLIC/GENERAL HEALTH MEDICINE ☐
- PULMONARY DISEASES ☐
- RADIOLOGY DIAGNOSTIC & THERAPUTIC INLUDING INTERVENTIONAL & RADIATION TX ☐
- RADIOLOGY DIAGNOSTIC & THERAPUTIC ☐
- RADIOPAQUE DYE ☐
- RHEUMATOLOGY ☐
- SHOCK THERAPY ☐
- SPORTS MEDICINE ☐
- THORACIC SURGERY ☐
- TRAUMA SURGERY ☐
- UNDERSEA/HYPERBARIC MEDICINE ☐
- URGENT CARE MEDICINE ☐
- UROLOGY (NO SURGERY) ☐
- UROLOGY (SURGERY) ☐
- VASCULAR SURGERY ☐

OTHER (PLEASE SPECIFY)

Please provide full details of all private work for which indemnity is required:

Practice Profile

13. Please state the approximate percentage split between each of the following categories:

i. Private Practice ____ % ii. Public Practice (Directly for HSE) ____ %

14. Please state the approximate number of sessions undertaken per week, for which you require indemnity, performed in each of the following categories (each session equates to c. 4 hours):

i. Surgery ____ ii. Consulations or Non-Surgical Work ____ iii. HSE ____

15. Please state the approximate number of procedures you perform per year in your independent practice for each of the following categories:

i. Minor ____ ii. Intermediate ____ iii. Major ____

16. Please state the approximate percentage of your overall practice which involves patients under 16 years of age ____ %

17. Do you plan to cease all practice within the next 5 years? Yes ☐ No ☐

18. Do you perform work outside the Republic of Ireland? (If Yes, Please provide additional details below) Yes ☐ No ☐

Additional Details:

Section 3 – Professional History

19. What year did you begin private practice? ____

20. Please provide details of current insurance, if applicable

i. Indemnity/Insurance provider ____ ii. Year first joined ____

iii. Renewal/Expiry Date Day Month 2030 iv. Subscription in current year ____

21. Has your indemnity been continuous since qualification? Yes ☐ No ☐

22. Has any application for this type of insurance cover or membership of any defence body ever been declined, cancelled or required special terms? Yes ☐ No ☐

23. Have any claims for compensation been made against you for incidents or circumstances arising from public or private practice during the last 10 years? (If "Yes", please provide the relevant date with brief details using additional space in Section 5) Yes ☐ No ☐

24. Are you aware of any circumstances, from your public or private practice, which may give rise to a claim against you? Yes ☐ No ☐

25. Have all of the above circumstances been notified and accepted by your current indemnity provider or insurer? Yes ☐ No ☐

26. Have you ever been convicted of any criminal offence (other than minor driving offences), and/or subject to professional disciplinary proceedings by your employer and/or IMC Fitness to Practice procedures? Yes ☐ No ☐

Section 4 – Financial Information

27. What is your gross annual income from your private practice, excluding both medico-legal and HSE indemnified work:

i. for the past accounting year? ____ ii. estimated for the full current accounting year? ____

28. What is your gross annual income from medico-legal work only in your private practice:

i. for the past accounting year? ____ ii. estimated for the full current accounting year? ____

29. Do you provide your services or bill your patients via a Limited Company? Yes ☐ No ☐

i. Please provide the company name and number ____

ii. Are you the only registered medical practitioner working for the company? Yes ☐ No ☐

iii. Is the company set up solely for fiscal reasons? Yes ☐ No ☐

i. Does the company employ any staff (other than clerical/admin staff)? Yes ☐ No ☐

v. If applicable, do you require cover for any of the staff included above? Yes ☐ No ☐

Section 5 – Additional Information

Section 6 – Declaration and Disclosure

I declare and warrant that, after enquiry, all statements and declarations contained in the completed Application Form, together with any and all other information, statements and declarations made to Insurers, or their representatives, by or on behalf of the Insured, whether written or oral, are true and that no information whatsoever has been withheld which might increase the risk to Insurers or influence the acceptance of this Application Form. Should the above statements and declarations alter in any way, I will advise Challenge as soon as practicable. I understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of this Application Form may result in the refusal to provide indemnity or voiding the policy in every respect. I hereby accept that this Declaration shall be the basis of the contract between both parties if entered into. By signing this document, I authorise Challenge to release information to necessary third parties and give permission for Challenge to use my email address, as provided in Section 1, to send their quotations or correspondence.

Customer Signature

Print Name

Date Day Month 2025