

Doctor Details

Please complete in full and return to the above address by post/fax or email.

This form should be completed by all medical professionals wishing to undertake medicals for Principle Medical Services Limited.

Name: _____

Qualifications: _____

GMC registration number: _____

Mobile telephone number: _____

D.O.B. _____ Date Registered: _____

Are you on the specialist register? yes no

If yes please list speciality? _____

Address at which medical will be carried out: *(If you carry out medicals at more than one centre please add second and subsequent addresses below.)*

Centre 1:

_____ p/code _____

Centre 2:

_____ p/code _____

Please give details of any other registration you have: *(example: Department of Transport/Aviation)*

Any other information you may wish to add: