

MEMBER REQUEST FOR ASSISTANCE

dentalprotection.org

Dental
Protection



Please complete all of the fields below:

Membership number

Title

First name(s)

Surname

Dental Council registration number

Date of birth (DD/MM/YYYY)

Address

Postcode

Email address

Telephone number(s)

My query relates to:

Claim

Ethical/legal dilemma

Medical Council issue

Criminal investigation

Generic medicolegal advice

Patient complaint

Defamation

Inquest

Other (please advise below)

Period of involvement (date of earliest interaction and date of last interaction with patient relevant to the incident giving rise to case)

From (DD/MM/YYYY)

to (DD/MM/YYYY)

Incident date (DD/MM/YYYY)

Private practice (tick as appropriate)

Yes

No

At the time of the incident, what was your Specialty?

At the time of the incident, what was your location?

At the time of the incident, what was your seniority/grade?

Name of hospital/clinic

Brief anonymised summary: (please detail below)

Patient initials

Patient year of birth (MM/YYYY)

Patient outcome

If applicable, patient date of death (DD/MM/YYYY)

Additional Information

If you have any additional documents that you wish to forward to us, it is not usually necessary to forward all the documents now. Please, however, keep these safe as they may be requested from you in the future.

To protect patient confidentiality, please ensure you do not provide us with any additional documentation which could allow a patient to be identified.

Important information (please tick)

☐ I confirm that I have not included any information that would allow a patient to be identified.

Signature: (Please enter your initials to sign)

Date: DD/MM/YYYY (Please note must be current date)