

Practitioner & Counter Fraud Services

Use this form to tell us about Maternity payments

Ref	Question	Answer
<b>About you</b>		
1	Dentist name:	
1a	GDC number:	
	List Number:	
	Previous List Numbers:	
1b	Contact telephone number:	
1c	Secure NHS email address:	
<b>Tell us about the position prior to the period of maternity leave</b>		
2	Name of Dentist going on maternity leave.	
2a	List number of Dentist going on maternity leave.	
2b	Proposed period of maternity leave.	__/__/____ to __/__/____
2c	Contracted hours of Dentist who is taking a period of maternity leave	Monday:    ___/___    ___/___ Tuesday:    ___/___    ___/___ Wednesday: ___/___    ___/___ Thursday:   ___/___    ___/___ Friday:       ___/___    ___/___ Saturday:   ___/___    ___/___
2d	Total numbers of contracted hours of Dentist taking a period of maternity leave.	Hrs.
<b>If covering a period of maternity leave – tell us about the position you will be covering</b>		
3	List number at new practice	
3b	Period of maternity leave to be covered	__/__/____ to __/__/____
3a	Contracted hours of maternity leave position to be covered.	Monday:    ___/___    ___/___ Tuesday:    ___/___    ___/___ Wednesday: ___/___    ___/___ Thursday:   ___/___    ___/___ Friday:       ___/___    ___/___ Saturday:   ___/___    ___/___
3b	Total numbers of contracted hours of Dentist covering maternity leave.	Hrs.
3c	Indicate the proportion of the list of the Dentist going on maternity leave that will be the responsibility of the Dentist providing maternity cover.	% or the entire list. (complete or delete as appropriate)
<b>If returning from a period of maternity leave</b>		
4	Are you returning to the same practice/position held prior to the period of maternity leave?	Yes / No (delete as appropriate)

4a	If returning to a different position/practice, please provide details of previous position held prior to the period of maternity leave.	Address:  List No.
4b	Date of return from maternity leave	__/__/____
4c	Contracted hours to be completed on return following period of maternity leave	Monday:    ___/___    ___/___ Tuesday:    ___/___    ___/___ Wednesday:  ___/___    ___/___ Thursday:   ___/___    ___/___ Friday:      ___/___    ___/___ Saturday:   ___/___    ___/___
4d	Total numbers of contracted hours of Dentist on return from maternity leave.	Hrs.
4e	Is the entire list to be the responsibility of the Dentist on return from maternity leave?	Yes / No (delete as appropriate. If no, please provide details in 4e)
4f	Indicate the proportion of the list of the Dentist returning from maternity leave that will be their responsibility.	%
4g	If not, then what is happening to the remaining proportion of the patient list?	
4h	Has a request for a bulk transfer been made? If so please provide the date of the transfer (if known).	
<b>Other information</b>		
5	If you are on a NHS Board list at either your previous or at a new practice, please confirm that you are providing telephone consultations to patients and that you have access to the practice to provide telephone consultations to patients.	
6	If you are on a NHS Board list at either your previous or new patient practice, please confirm that you have not refused to work in emergency treatment centres if you have been requested to do so by the NHS Board.	

I confirm that the information provided above is correct and complete to the best of my knowledge. If it is found not to be, appropriate action may be taken against me. I understand that the information on this form may be used for the purposes of detection and prevention of fraud, calculation of payments and for statistical purposes.

Personal data is processed by NHS National Services Scotland in accordance with our data protection notice <https://nhsns.org/services/practitioner/data-protection>.

Signed	
GDC number	
Date	