

PLASTIC AND RECONSTRUCTIVE SURGERY SUPPLEMENTARY QUESTIONNAIRE

Please use the data from your last successfully submitted annual appraisal to complete this questionnaire.

1.1 Please state whether you are employed by the NHS as a Consultant Plastic Surgeon:

Yes

No

1.2 Please state whether you have a sub-specialty interest:

Yes

No

a) If yes, please state the sub-specialty organisations of which you are a member:

b) Please state the number of PAs, or equivalent time in Private Practice, spent performing your sub-specialty activities per week in Private Practice and the NHS:

Sub-specialty	Private Practice	NHS
Aesthetic surgery (cosmetic only):		
Breast surgery:		
Cancer:		
Congenital conditions:		
Hand and upper limb surgery:		
Head and neck:		
Skin:		
Trauma:		
Other:		
Total:		

If other, please provide full details:

1.3 Please provide a full breakdown of the number of surgical procedures you performed during the last year in Private Practice and the NHS:
If you have not performed any procedures during the last year, please provide estimated numbers of procedures for the current year.

Surgical procedure:	Private Practice	NHS	Total number of years' experience in this field
Face/Head:			
Blepharoplasty – lower:			
Blepharoplasty – upper:			
Brow lift:			
Cheek implants:			
Chin implants:			
Full facelift including brow:			
Neck lift:			
Otoplasty:			
Short scar facelift:			

Surgical procedure:	Private Practice	NHS	Total number of years' experience in this field
Nose:			
Rhinoplasty – open:			
Rhinoplasty – closed:			
Breast:			
Augmentation:			
Correction of gynaecomastia:			
Implant removal:			
Mastopexy:			
Reduction:			
Genital:			
Clitoral hood reduction:			
Labiaplasty:			
Penile surgery or enhancement:			
Vaginoplasty or rejuvenation:			
Skin:			
Excision of skin lesions:			
Mole removal:			
Skin grafts:			
Other procedures:			
Adominoplasty:			
Arm (brachioplasty), buttock or thigh lifts:			
Buttock, calf or pectoral Implants:			
Fat transfer:			
<i>If yes, please state which part of the body this involves:</i>			
Hair transplant:			
<i>Please state which method you use:</i>			
Hand surgery:			
Liposuction:			
Other procedures (<i>see below</i>):			
Total number of procedures:			

If other, please provide full details:

1.4 Please provide a breakdown of the following procedures you performed during the last year in Private Practice and the product or system used:

If you have not performed any procedures during the last year, please provide estimated numbers of procedures for the current year.

Procedure	Number of procedures	Product or system used
Body contouring:		
Botox - face:		
Botox - platysmal bands:		
Chemical peels:		
Dermabrasion:		
Dermal fillers - permanent:		
Dermal fillers - semi-permanent:		
Dermal fillers - temporary:		
Hyperhidrosis:		
Lipotherapy:		
Mesotherapy:		
Sclerotherapy:		
Other procedures <i>(see below)</i> :		
Laser:		
Laser lipolysis:		
Laser/IPL hair removal:		
Laser/IPL skin tightening or resurfacing:		
Tattoo removal:		
Vaginal tightening:		
Total:		

If other, please provide full details:

1.4 Please state whether you have ever used PIP implants or macrolane in Private Practice:

Yes

No

If yes, please state:

a) the number and type of any procedures performed during the last year:

b) the date of the last procedure you performed in Private Practice:

MM / YY

1.5 Please state whether you have ever performed, or assisted in, bariatric surgery: Yes No

a) If yes, please provide a breakdown of the number of procedures you performed during the last year in Private Practice and the NHS and how many years you have performed these procedures:

Procedure	Private Practice	NHS	Number of years' experience performing this procedure
Gastric balloon:			
Gastric band:			
Gastric bypass:			
Gastric sleeve:			
Total:			

b) If you have performed secondary bariatric surgery, please state the nature of the surgery and number of procedures performed:

c) If you no longer perform, or assist in, bariatric surgery please state the date of the last procedure you performed in Private Practice:

MM / YY

1.5 Do you work for Transform or Harley Medical? Yes No

If yes, please state the average number of hours and procedures performed per week:

Number of hours per week:	Number of procedures per week:

1.6 Do you anticipate any changes to your activities during the next 12 months? Yes No

If yes, please provide full details.

DECLARATION

I declare that:

- after full enquiry the answers to the questions contained in this application form, and any other information supplied by me, are substantially true, accurate and correct;
- I will inform underwriters before cover incepts of any change to the information supplied by me; and
- I understand that if any of the information contained in this application form or provided elsewhere is substantially untrue, inaccurate or incorrect, or I have not disclosed any other information that is material, the Policy may be avoided without any return of premium, the terms and conditions may change, a higher premium may become payable or we may reduce the amount of any claim payment.

Signed: _____ Full name: _____

Date: _____ DD / MM / YY

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