

## 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:

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Yes

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No

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

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Yes

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No

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

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

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

*If other, please provide full details:*

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1.3 Please provide a full breakdown of the surgical procedures you performed during the last year in Private Practice and the NHS:

| Surgical procedure:           | Surgical procedure performed in Private Practice only? |     |  |    | Number of years' experience in this field | Private Practice | NHS |
|-------------------------------|--|-----|--|----|---|------------------|-----|
| Face/head:                    |  |     |  |    |   |                  |     |
| Blepharoplasty – lower:       |  | Yes |  | No |   |                  |     |
| Blepharoplasty – upper:       |  | Yes |  | No |   |                  |     |
| Brow lift:                    |  | Yes |  | No |   |                  |     |
| Cheek implants:               |  | Yes |  | No |   |                  |     |
| Chin implants:                |  | Yes |  | No |   |                  |     |
| Full facelift including brow: |  | Yes |  | No |   |                  |     |
| Neck lift:                    |  | Yes |  | No |   |                  |     |
| Otoplasty:                    |  | Yes |  | No |   |                  |     |
| Short scar facelift:          |  | Yes |  | No |   |                  |     |

| Surgical procedure:  | Surgical procedure performed in Private Practice only? |     | Number of years' experience in this field | Private Practice | NHS |
|--|--|-----|---|------------------|-----|
| Nose:  |  |     |   |                  |     |
| Rhinoplasty – open:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Rhinoplasty – closed:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Breast:  |  |     |   |                  |     |
| Augmentation:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Correction of gynaecomastia:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Implant removal:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Mastopexy:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Reduction:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Genital:   |  |     |   |                  |     |
| Clitoral hood reduction:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Labiaplasty:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Penile surgery or enhancement:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Vaginoplasty or rejuvenation:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Skin:  |  |     |   |                  |     |
| Botox - face:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Botox - platysmal bands:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Chemical peels:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Demal Fillers - permanent:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Demal Fillers - semi-permanent:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Demal Fillers - temporary:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Dermabrasion:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Excision of skin lesions:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Hyperhidrosis:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Laser Surgery:<br><i>If yes, please state which areas of the body:</i>   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Mole removal:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Skin grafts:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Tattoo removal:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Other:   |  |     |   |                  |     |
| Adominoplasty:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Arm, buttock or thigh lifts:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Brachioplasty:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Buttock, calf or pectoral Implants:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Fat transfer:<br><i>If yes, please state whether this involves the face, breast or other part of the body:</i> | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Hair transplant:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Hand surgery:  | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Liposuction:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Other:   | <input type="checkbox"/>                               | Yes | <input type="checkbox"/>                  | No               |     |
| Total:   |  |     |   |                  |     |

*If other, please provide full details:*

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

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Yes

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No

If yes, please state:

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

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

1.5 Please state whether you have ever performed, or assisted in, bariatric surgery:

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Yes

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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:

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

1.6 Do you anticipate any changes to your activities during the next 12 months?

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Yes

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No

If yes, please provide full details.

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## 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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