

# Application for a change of Responsible Person of a Body Corporate

Please complete in BLOCK CAPITALS and in black ink.

## Section 1 - General information on the Care Service

Name of Care Service

Address of Care Service

  
  

Postcode

Telephone number

Email address

### Name of the Body Corporate

The Registered Office/Principal Office of the body corporate

Name

Address

  
  

Postcode

Company registered number

Email address

## Section 2 - Personal information

Full Name

Other names by which you have been known

Date of birth

Telephone number

Email address

Address

  
  

Postcode

I have lived here from

Previous Address

  

Postcode

Date from

Date to

Please provide the details of all other addresses where you have lived in the last 5 years. If applicable please continue on a separate sheet.

Do you require a work permit?

Yes

No



**Current employment details**

Name of employer

Address of employer

Postcode

Telephone number

Job Title

Responsibilities

Date commenced  /  /  **Full Time**  **Part Time**

If you already manage the establishment/agency to which this application applies, please state date commenced  /  /

Will you also be responsible for the management of any other establishment/ agency/service not included in this application? **Yes**  **No**

If **Yes**, please provide details

**Previous employment**

**Please enclose a comprehensive Curriculum Vitae including all past employment history since leaving full time education (most recent first). Please explain any gaps and provide reasons for leaving each job.**

Have you ever been employed by a registered care establishment/agency/service? **Yes**  **No**

If **Yes**, please provide details

Please give details of any previous application to register an establishment/agency as a responsible individual or manager.

Name of area to which application is made	Capacity (Responsible individual/ manager)	Date of Application	Outcome (approved/refused)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Relevant work experience**

Please give details of the relevant experience and ability you have which will enable you to supervise the management of the service:

Management of this specific type of service

Experience of work with clients proposed

Staff management and support

Day to day administration

## Registration with professional bodies

Please provide the following information if registered with a professional body

Professional body	Date of Registration	Level of Registration	PI Number (if applicable)	Expiry Date

## Referees

Please give the name and address of two referees:

- they must not be related to you;
- our reference request will ask for details of your competence to provide the service for which you are applying for;
- one of the referees must be your current or last employer.

### Referee 1: Name

Job title

Address

  
  

Postcode

Telephone number

Capacity in which you are known to referee

### Referee 2: Name

Job title

Address

  
  

Postcode

Telephone number

Capacity in which you are known to referee

## Declaration of interests

a) Do you have any current financial or managerial interest in any other care service?

Yes

No

b) Have you ever been registered for, or been the proprietor or manager of, any care service?

Yes

No

If **YES** please provide details:

Name and address of establishment/agency	Nature and extent of interest

**SECTION 3 - Disclosure and Declarations**

Have you ever:

been involved as an owner or manager of, or had a financial interest in, a voluntary or registered service whose registration has been refused or cancelled?

Yes

No

If you have answered **YES** to the above questions, please supply below the dates, circumstances, outcomes, the name of the local authority area in which you were living and, if applicable, any social services departments from other local authorities who were involved. (Please use an additional sheet of paper if necessary)

Are you disqualified from registration as listed in the Regulation of Care Act 2013 Sections 43, 44, 45 and 46?

Yes

No

If you have answered **YES** please provide details:

Are you applying for an exemption from disqualification?  
Please see the Regulation of Care Act 2013 Section 47

Yes

No

If you have answered **YES** please provide details:

**SECTION 3 - continued**

You are required to declare any convictions, cautions, conditions/unconditional discharges and bindovers. This includes declaring all 'spent convictions' in accordance with the Rehabilitation of Offenders Act (Exemption Order) 2001 and Rehabilitation of Offenders Act (Exemption Order) 1975 (UK).

A criminal conviction will not necessarily lead to a refusal of your application. However, failure to disclose any convictions could lead to either your application being refused or, if your application is successful, cancellation of your registration if it is subsequently learnt that you had a criminal conviction at the time you made the application.

Have you ever:

- been convicted of a criminal offence, cautioned or bound over by any court?      **Yes**       **No**
- Are you currently under police investigation?      **Yes**       **No**

If **Yes**, please give details:

In addition, please indicate whether you have ever been:

- subject to child protection enquiry/investigation?      **Yes**       **No**
- subject to adult protection enquiry/investigation?      **Yes**       **No**
- Investigation/proceeding under any Act on the Isle of Man or any Act in other jurisdictions?      **Yes**       **No**

Employed by, or in any way associated with, an establishment/agency which has been the subject of:

- Police investigation      **Yes**       **No**
- Registration and Inspection Unit investigation      **Yes**       **No**
- Child Protection investigation      **Yes**       **No**
- Adult Protection investigation      **Yes**       **No**

If **Yes** to any of the above, please give details including dates:

Please complete and sign the declaration below:

**I hereby declare that the information detailed above is accurate to the best of my knowledge. I understand that it is an offence knowingly to make a statement which is false or misleading in a material respect in this application or any of the documents submitted with this form as part of this application.**

**In making this application for registration under the Regulation of Care Act 2013. I agree to comply with the Act and all associated regulations. I agree to comply with the standards in place for the service.**

**I understand that the Department of Health and Social Care will undertake any background searches it feels appropriate, including criminal conviction checks, personal and financial references and social service checks to ascertain suitability.**

**I understand in order to carry out the background searches the Department may seek information from the following: Social Service records, Child protection registers, Health Services, Mental Health Services, International Social Services, Ministry of Defence, previous employers, the lists kept under the Disclosure and Barring Scheme.**

**Other organisations which may be contacted include: the NSPCC, Ofsted, other previous registering authorities, the Probation Service, the Work Permit Office, Immigration, the Electoral Roll and any other organisations the Department believes it is necessary to approach in order to reach an opinion as to the suitability of an applicant.**

**Signed**

**Print Name**

**Date**

**Issued by:**

Registration and Inspection Team  
Department of Health and Social Care  
1<sup>st</sup> Floor Belgravia House  
34-44 Circular Road  
Douglas, Isle of Man, IM1 1AE

Tel: +44 1624 642422

Email: RandI@gov.im

Checklist - Responsible Person	Tick Box
Documents to support application	
Fully completed application form	<input type="checkbox"/>
Application fee (link) <a href="https://www.gov.im/about-the-government/departments/health-and-social-care/registration-and-inspection-team/health-and-social-care-providers-area/">https://www.gov.im/about-the-government/departments/health-and-social-care/registration-and-inspection-team/health-and-social-care-providers-area/</a>	<input type="checkbox"/>
Original Qualification certificates	<input type="checkbox"/>
Current CV	<input type="checkbox"/>
Medical Opinion Form completed and signed by a GP ( <i>attached to pack</i> )	<input type="checkbox"/>
Documents to support DBS & ID check	
Valid Role specific DBS certificate **	<input type="checkbox"/>
Passport sized photograph	<input type="checkbox"/>
Passport	<input type="checkbox"/>
Driving licence	<input type="checkbox"/>
Utilities bill or bank statement ( <i>dated within 3 months</i> )	<input type="checkbox"/>
Work Permit if required	<input type="checkbox"/>

\*\* Pre-existing DBS certificates will only be accepted if they can be authenticated via the online checking service (if you have signed up for portability) OR they are less than 3 months old. Hardcopy of DBS certificate must be seen by R&I on appointment.

Application forms **MUST** include **all** relevant documentation as per checklist. If evidence supporting the application is not provided, the application **will not be accepted**.

Once application completed and **all** supporting evidence attached, please make an appointment to attend the office for payment, submission, DBS and ID check.





# Medical opinion form

**This section to be completed by the applicant for registration to provide or manage a care service.**

Type of care service proposing to provide	<input type="text"/>
Full Name	<input type="text"/>
Date of birth	<input type="text" value="/ /"/>
Home address	<input type="text"/> <input type="text"/> <input type="text"/>
	Postcode
Telephone number	<input type="text"/>
Name of General Practitioner	<input type="text"/>
Address of General Practitioner	<input type="text"/> <input type="text"/> <input type="text"/>
	Postcode

**This section to be completed by the applicant's General Medical Practitioner or other doctor with knowledge of the applicant's health.**

In respect of the application made by the above named person, I confirm that there is nothing in the patient's available GP medical records that would give cause for concern with regard to fitness for registration.  Yes (please Tick)

If **No** please indicate whether any cause for concern which would preclude the applicant being registered to manage or provide a care service subject to any limitations stated below.

**Signed**

**Print Name Date**

**Issued by:**

**Registration and Inspection Team,  
1st Floor, Belgravia House, 34-44  
Circular Road, Douglas, IM1 1AE**

Official Surgery Stamp: