

# Surrender Application - Individual/Partnership/Body Corporate

Please complete in BLOCK CAPITALS and in black ink.

**This form should be completed by: -**

- the registered provider or a person with the authority to represent the registered provider/person (excluding childminders)

This form must be sent or delivered to the Department of Health and Social Care (DHSC) -

- (i) not less than 3 months before the proposed effective date of surrender; or
- (ii) within such shorter period (if any) before that date as may be agreed with DHSC

**Registered managers** are required to formally notify the DHSC if they surrender their own registration. This will be required if they are **not** going to continue to manage the same service at the same locations under a new provider.

Please tell any managers who are affected by this and inform them that if this application is successful, they will be required to notify the DHSC formally in writing that they are surrendering their registration.

## Section A - Service Provider

Name of care service	<input type="text"/>
Address of care service	<input type="text"/>
	<input type="text"/>
	<input type="text" value="Postcode"/>
Telephone number	<input type="text"/>
Email address	<input type="text"/>
<b>Name of Registered Provider</b>	<input type="text"/>
Address (if different from service address)	<input type="text"/>
	<input type="text"/>
	<input type="text" value="Postcode"/>
Telephone number	<input type="text"/>
Email address	<input type="text"/>

## Section B - Surrender of Registration

Date of proposed surrender of registration

If your application is less than three months before the proposed effective date of surrender, please enclose a report with this application as to whether -

- (i) the establishment or agency has ceased to be financially viable; or
- (ii) is likely to cease to be financially viable within the next following twelve months.



Reason for surrender of registration

What arrangements have you made to ensure that users of the service will continue to receive a similar service, this may include from another provider or person either at the same location or a different location.

Have you notified the following of your proposal to surrender registration of your service?

- Service recipients **Yes**  **No**
- Representatives/relatives of service recipients **Yes**  **No**

If you have not notified the relevant parties, please provide the reasons why and your intended action here:

**Section C - Application declaration**

This declaration must be signed by the applicant.

If the applicant is a body corporate, an authorised representative of the body corporate must sign this application.

If the applicant is a partnership, it must be signed by each member of the partnership.

I/We declare that the information given in this application is, to the best of my/our knowledge and belief, complete and correct.

**Signed**

**Print Name**

**Position**

**Date**

The DHSC Registration and Inspection Unit is not able to process this application until all relevant information is received.

**Partnerships ONLY—additional partners:**

**Signed**

**Print Name**

**Position**

**Date**

**Signed**

**Print Name**

**Position**

**Date**

**Issued by:**

Registration and Inspection Unit  
Department of Health and Social Care  
Ground Floor, St George's Court, Hill Street, Douglas  
Isle of Man  
IM1 1EF

Tel: +44 1624 642422

Email: RandI@gov.im