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Registration under the Health and Social Care Act 2008
(as amended)

##### Application for registration as a new provider of regulated activities

For all applicants

January 2025

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| There is detailed guidance on our [website](http://www.cqc.org.uk/applicationhelp) to help you fill in and submit this form: ‘**How to fill in the application form for registration……….’**If you roll your cursor over any **(See Guidance)** and left click your mouse it will take you to the guidance for that section. **When you are completing your application form online it is recommended that you have the guidance open for each section when completing it.**The guidance should be considered as an important part of the application process and it will be presumed that the applicant has read and followed it on submitting the application. |

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## Statement on Data Protection

You must sign the statement below. If you don’t, we will return your application.

The person who signs below must be one of the following: -

**Organisation:** Any individual authorised to do so by the Organisation

**Partnership:** Must be a member of the partnership identified in section 3.4

**Individual:** Must be the individual

Submitting this form electronically we will accept a typed-in name as your signature.

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| I/we understand that CQC will use the information provided on this form (including personal data) and other relevant information that it obtains or receives, for the purposes of performing its regulatory functions in accordance with the Health and Social Care Act 2008.In particular, this information will be used to make decisions about the registration of providers and managers and in relation to the inspection and regulation of services.This includes publication of:* A register of providers
* Conditions of registration
* Reports about meeting the regulations
* Other information that we may publish to assist the public in understanding the quality of services and the regulatory actions of the Commission.

Information (including contact information and other personal data) may also be shared with other regulators and public bodies where necessary or expedient to assist them in carrying out tasks in the public interest.Registration application forms are processed on behalf of CQC. CQC will use and protect personal data in accordance with data protection law.Full information on how CQC processes personal data, and on your rights as a ‘data subject’ are published on our website at <http://www.cqc.org.uk/about-us/our-policies/privacy-statement> |
| \*Applicant’s signature |       |
| \*Applicant’s full name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |

## \*Statement of Purpose

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| You must draft and send us a Statement of Purpose with this application form. **If you do not, we will return your application to you.**The guidance to filling in this form contains a summary about what the law says must be included in your Statement of Purpose. There is also separate detailed guidance on Statements of Purpose on our [website](https://www.cqc.org.uk/guidance-regulation/providers/registration/statement-purpose). |

**Section 1: Where the applicant is an organisation**

**If you are NOT applying as an organisation please go to** [**section 2**](#Section2) **(individual) or**[**section 3**](#Section3) **(partnership) as appropriate.**

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| **\*1.1 The organisation’s name and contact details** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp1) |
| \*Organisation’s name |       |
| Name you trade under if different to the above |       |
| The registered office of the organisation (if applicable) or its principal office: |
| \*Address line 1 |       |
| \*Address line 2  |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| Website |       |
| \*Business telephone number |       |
| Mobile telephone number |       |
| \*Please specify the legal status of the provider organisation e.g. (public limited company/limited company/charity/ limited liability partnership/joint venture/ subsidiary/ other) If ‘other’ has been selected as the legal status above, please give particulars (for example a franchise) |       |
| \*Registered company number (if applicable) |       |
| \*Registered charity number (if applicable)  |       |
| \* Any other number (if applicable)  |       |

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| By submitting this application you are confirming the provider’s willingness, if its application for registration is granted, for CQC to use the **email address** shown at 1.1 above for service of notices and other documents including draft and final inspection reports and for sending all other correspondence.If you **DO NOT** want to receive these by email please check or tick the box below. |
| We do **NOT** wish to receive notices and other documents including draft and final inspection reports and correspondence from CQC by email | [ ]  |  |

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| **1.2 Alternative temporary correspondence address** |
| **Do not complete this section if it is the same as the above address.****If you wish to provide an alternative temporary correspondence address we will only use this whilst processing your application.** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp2) |
| Contact Name |       |
| Address line 1 |       |
| Address line 2  |       |
| Town/city |       |
| County |       | Postcode |       |
| Telephone |       |
| Email address |       |

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| **\*1.3 Is your organisation a subsidiary of another company?** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp3) |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘No’, please go to [Section 1.7](#Section1_7)If ‘Yes’, please provide the name and address of the parent/holding company |
| \*Name  |       |
| \*Property name (if any) |       |
| \*Business address line 1 |       |
| \*Business address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| Website |       |
| \*Business telephone number |       |
| \*Registered company number (if applicable) |       |
| \*Registered charity number (if applicable) |       |

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| **1.4 More information about parent and subsidiary companies**[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp4) |
| Please detail the financial relationship between your organisation and any parent and/or subsidiaries. In particular does your organisation rely financially on any other organisations within the group? |
|       |
| Do you share a brand name with other organisations?If ‘Yes’, what is the financial relationship between your organisation and other organisations within the brand, in particular does your organisation rely financially on any other organisations within the brand? |
|       |

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| **\*1.5 Is your organisation a franchise?** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp3) |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘No’, please go to [Section 1.7](#Section1_7)If ‘Yes’, please provide the name and address franchisor |
| \*Name  |       |
| \*Property name (if any) |       |
| \*Business address line 1 |       |
| \*Business address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| Website |       |
| \*Business telephone number |       |
| \*Registered company number (if applicable) |       |
| \*Registered charity number (if applicable) |       |

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| **1.6 More information about the franchisor**[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp4) |
| Please detail the financial relationship between your organisation and any franchisee. In particular does your organisation rely financially on any other organisations within the group? |
|       |
| Do you share a brand name with other organisations?If ‘Yes’, what is the financial relationship between your organisation and other organisations within the brand, in particular does your organisation rely financially on any other organisations within the brand? |
|       |

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| **\*****1.7 Directors or equivalent** |
| Under roles and responsibilities please record any **professional registration numbers and professional body/s**. Please also tell us about any specific roles they have in relation to quality and safety within this organisation. Please tell us about any roles or responsibilities with other organisations.[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp5) |
| \*Chair | Title       | First       | Middle       | Last       |
| \*Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| \*Secretary (or equivalent) | Title       | First       | Middle       | Last       |
| \*Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| \*Email address |       |
| \*Roles and responsibilities |       |
| \*Chief Executive (or equivalent) | Title       | First       | Middle       | Last       |
| \*Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| \*Email address |       |
| \*Roles and responsibilities |       |
| Member 4 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 5 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 6 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 7 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 8 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 9 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 10 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 11 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 12 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 13 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |
| Member 14 | Title       | First       | Middle       | Last       |
| Job Title/Role |       |
| Date of birth (dd/mm/yyyy) |       | Business/mobile telephone number |       |
| Email address |       |
| \*Roles and responsibilities |       |

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| **\*1.8 Declaration on meeting regulation 5** |
| The Chair (or equivalent) of this service provider must complete this section of the formI declare that all relevant checks and enquiries have been carried out in the appointment of the directors listed above. I confirm that all directors are fit and none meet any of the unfitness criteria specified in Part 1 of Schedule 4 to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

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| I declare I have undertaken a risk assessment of all disclosures from our directors. Where information exists about any individual relevant to Schedule 4, Part 1 and Part 2, I have detailed below. I consider the individual to be suitable and have provided my reasons below for reference as defined under Regulation 17 5 (3) (a)” |
|       |

|  |  |
| --- | --- |
| \*Chair’s signature |       |
| \*Chair’s full name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |

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| **\*1.9 Nominated individual(s)** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp6) |
| Provide details of the nominated individual (NI) for each regulated activity in this application.The first person listed will be the main NI to whom we will send noticesDownload additional nominated individual sections from the website page where you found this form if you intend to provide more than one regulated activity and plan to have more than one nominated individual.**If you don’t submit a form for each nominated individual, we will return your application.** |

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| The information below is for nominated individual number: | **1** | of a total of: |    | nominated individuals |

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| **\*Details of a nominated individual for regulated activities** |
| \*Regulated activity(s)(From the list of regulated activities checked or ticked at Section 5 below) |       |
| \*Full name | Title        | First       | Middle       | Last       |
| Previous name (if applicable) |       |
| \*Date of birth (dd/mm/yyyy) |       |
| \*Business address line 1 |       |
| \*Business address line 2  |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| \*Business telephone |       |
| Mobile telephone |       |
| Professional Body name |       |
| Professional registration number |       |
| Professional Body name |       |
| Professional registration number |       |
| Please confirm that the Nominated Individual is:* Of good character.
* Physically and mentally fit to supervise the management of the carrying on of the regulated activity.
* Has the necessary qualifications, skills and experience to do so; and
* Has supplied the registered person, or arranged for the availability of, the information specified in Schedule 3 to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
 |
|  Yes | [ ]  |  No | [ ]  |  |
|  |
| Have you applied for and received an enhanced DBS disclosure for the person shown (if you have not done so we will return your application). |
| Yes | [ ]  | No | [ ]  |  |
|  |
| DBS disclosure number |       | Date of disclosure (dd/mm/yyyy) |       |

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| **\*1.10 Professional body disciplinary proceedings, other investigations, or bars on activity by the Disclosure and Barring Service (DBS)** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp7) |
| Are any of the members of the Board or similar body at 1.7 or any Nominated Individuals proposed in section(s) 1.9 subject to, at any time, any professional disciplinary action, proceedings, investigations or restrictions or bars on activity by a health or care professional regulator or the Disclosure and Barring Service Relevant health and care professional regulators or professional bodies may include, but are not limited to, those such as: * The General Chiropractic Council (GCC)
* The General Dental Council (GDC)
* The General Medical Council (GMC)
* The General Optical Council (GOC)
* The General Osteopathic Council (GOsC)
* The Health and Care Professions Council (HCPC)
* The Nursing and Midwifery Council (NMC)
* General Pharmaceutical Council (GPhC)
* Pharmaceutical Society of Northern Ireland (PSNI)
* Northern Ireland Social Care Council (NISCC)
* Social Care Wales
* Scottish Social Services Council (SSSC)

Please either check or tick ‘yes’ or ‘no’. Please provide details below

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes | [ ]  |  No | [ ]  |  |

 |
| If ‘Yes’, please provide details below. |
|       |
| Are any of the members of the board or similar body at 1.7 or any Nominated Individuals proposed in section(s) 1.9 subject to any professional disciplinary action, current proceedings, investigations or restrictions or bars on activity by a health or care professional regulator or the Disclosure and Barring Service? |
| Yes | [ ]  |  No | [ ]  |  |
|  |
| If ‘Yes’, please provide details below. |
|       |

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| **\*1.11 Previous registration history** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp8) |
| Has your organisation, any parent organisation, franchisee or subsidiary, or any of the directors or equivalent ever been registered or licensed for, or been the owner of any service registered or licensed under any of the following Acts of Parliament? (check / tick for ‘Yes’, leave blank for ‘No’) |
|  | The Registered Homes Act 1984 | [ ]  |  |
|  | The Registered Homes (Amendment) Act 1991 | [ ]  |  |
|  | The Children Act 1989 (including child-minding and day care for children) | [ ]  |  |
|  | The Nurses Agencies Act 1957 | [ ]  |  |
|  | The Care Standards Act 2000 | [ ]  |  |
|  | Health and Social Care Act 2008 | [ ]  |  |
| If ‘Yes’, please provide details below. |
|       |
| Was the registration of the organisation ever cancelled?If ‘Yes’, please provide details below. |
|       |

**You will need to submit a registered manager application. Please see our website** [**here**](http://www.cqc.org.uk/content/applying-new-provider-guidance)**.**

**Please proceed to** [**section 4**](#Further) **to continue completing your application.**

**Section 2: Where the applicant is an individual**

**If you are NOT applying as an individual please go to** [**section 1**](#Section1) **(organisation) or**[**section 3**](#Section3) **(partnership) as appropriate**

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| **\*2.1 The applicant’s name and contact details** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp9) |
| \*Full name | Title       | First       | Middle       | Last       |
| \*Date of birth (dd/mm/yyyy) |       |
| Previous name (if applicable) |       |
| Name you will trade under if not your name |       |
| \*Address line 1 |       |
| \*Address line 2  |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| Website |       |
| \*Business telephone |       |
| Mobile telephone |       |
| By submitting this application you are confirming your willingness for CQC to use the **email address** shown at 2.1 above for service of notices and other documents including draft and final inspection reports and for sending all other correspondence to you.You will be required to provide proof of your identity as part of this application, this must include a recent photo. **DO NOT** send this with your application, you will be asked to provide this information during the assessment of your application.If you **DO NOT** want to receive these by email please check or tick the box below. |
| I do **NOT** wish to receive notices and other documents including draft and final inspection reports and correspondence from CQC by email | [ ]  |  |

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| **2.2 Alternative temporary correspondence address** |
| **Do not complete this section if it is the same as the above address.****If you wish to provide an alternative temporary correspondence address we will only use this during your application period.** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp10) |
| Contact Name |       |
| Address line 1 |       |
| Address line 2  |       |
| Town/city |       |
| County |       | Postcode |       |
| Telephone |       |
| Email address |       |

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| **\*2.3 Previous history as a registered person** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp11) |
| Have you ever been registered as manager, provider or nominated individual of an establishment, agency or service registered under any of the following Acts of Parliament?(check/tick for ‘Yes’, leave blank for ‘No’) |
|  | The Registered Homes Act 1984 | [ ]  |  |
|  | The Registered Homes (Amendment) Act 1991 | [ ]  |  |
|  | The Children Act 1989 (including child minding and day care for children) | [ ]  |  |
|  | The Nurses Agencies Act 1957 | [ ]  |  |
|  | The Care Standards Act 2000 | [ ]  |  |
|  | Health and Social Care Act 2008 | [ ]  |  |
| If you have answered ‘Yes’ to any of the above, please include details in section 2.4  |
| If you have ever been registered as a manager, provider or nominated individual of an establishment, agency or service registered under any of the following Acts of Parliament. Has your registration ever been cancelled? If ‘yes’ please provide the reasons below. |
|       |

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| **\* 2.4 Employment History (including previous history as a registered person)** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp12)Please provide details of your full employment history, if applicable please indicate where you were a registered person and the dates you were registered.* Please say why you left each post.
* Please explain any gaps in employment.

Please show dates in the format dd/mm/yyyy. |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |

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| Reasons for gaps in employment  |
|       |

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| **\*2.5 Day-to-day management of regulated activities** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp13) |
| **If you will be in full-time day to day charge of the carrying on of the regulated activities, you do not need to complete a registered manager application.**Will a registered manager or managers be in day-to-day charge of regulated activities at any of the locations in Section 6 below? |
| Yes | [ ]  |  No | [ ]  |  |
|  |
| **If ‘Yes’, their applications must be submitted with this form. If they are not, we will return your application** |

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| **\*2.6 Medical history** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp14) |
| Do you have any physical or mental health conditions that are relevant to your ability to carry on the regulated activities in this application for registration? |
| Yes | [ ]  |  No  | [ ]  |  |
|  |
| If you answered ‘Yes’, please provide details below Please describe any arrangements you have put in place, including any reasonable adjustments, to enable you todo your job. |
|       |
| **Please note:** **you should tell CQC of any significant changes to your health after you are registered.** |

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| **\*2.7 Your GP** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp15) |
| We may need to contact your doctor about your application. Please supply their contact details below. |
| \*GP’s name | Title       | First       | Middle       | Last       |
| \*Surgery name |       |
| \*Address line 1  |       |
| \*Address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*I give permission for the Care Quality Commission to contact my doctor or their surgery. |
| Yes | [ ]  | No | [ ]  |  |

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| **\*2.8 Qualifications, skills and experience** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp16) |
| If you plan to manage the regulated activities in this application on a day-to-day basis, and will be in full-time day-to-day charge of the carrying on, please give details of your relevant qualifications, skills and experience.**Please note:** If you will not be in full-time day-to-day charge of the carrying on of any of the regulated activities you are applying for, you will need a registered manager for those activities and they must submit the relevant form. |
|       |

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| **\*2.9 Declarations by a health or social care professional** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp17) |
| Professional Body name |       |
| Professional registration number |       |
| Professional Body name |       |
| Professional registration number |       |
| Are you currently the subject of, or have you ever been subject of, any investigation or proceedings by any professional body with regulatory functions in relation to health or social care professionals (including by a regulatory body in another country)? |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes’, please provide details below. |
|       |
| Are you currently the subject of, or have you ever been subject of any safeguarding investigation?  |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes’, please provide details below. |
|       |
| Have you ever been disqualified from the practice of a profession or required to practice subject to specified limitations following a fitness to practice investigation by a regulatory body in the UK or another country? |
| Yes | [ ]  |  No | [ ]  |  |
|  |
| If ‘Yes’, please provide details below. |
|       |

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| **\*2.10 Disclosure and Barring Service criminal records disclosure** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp18) |
| In the last 12 months, have you either:Applied for and received an **enhanced** DBS disclosure, that was **countersigned by CQC? (Please provide your most recent disclosure number)** |
| Yes | [ ]  |  No  | [ ]  |  |
| Or:Have obtained an enhanced DBS disclosure through membership of a professional body ([see the list on the CQC website](https://www.cqc.org.uk/guidance-providers/registration/dbs-checks-cqc-registration)), and have posted the original DBS certificate to CQC |
| Yes | [ ]  |  No | [ ]  |  |
| **NB: If you have not done so, we will return your application** |
| DBS disclosure number |       |
| Date of disclosure (dd/mm/yyyy) |  |

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| **\*2.11 Reference** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp19) |
| We will need to contact a referee about your application. Please supply contact details for a suitable referee belowYour referee must be your last employer. If you do not have a last employer, your referee:* Must not be related to you.
* Must be able to provide a reference as to your competence to provide the service.
* Must have employed or worked with you for a period of at least three months (unless this will be your very first job).
 |
| \*Referee’s name | Title       | First       | Middle       | Last       |
| \*Address line 1  |       |
| \*Address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| \*Telephone no. |       |
| \*I give permission for the Care Quality Commission to contact my referee. |
| Yes | [ ]  |  No | [ ]  |  |

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| **\*2.12 Is your business a franchise?** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp3) |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘No’, you do not need to complete section 2.12 or section 2.13If ‘Yes’, please provide the name and address franchisor |
| \*Name  |       |
| \*Property name (if any) |       |
| \*Business address line 1 |       |
| \*Business address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| Website |       |
| \*Business telephone number |       |
| \*Registered company number (if applicable) |       |
| \*Registered charity number (if applicable) |       |

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| **2.13 More information about the franchisor**[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp4) |
| Please detail the financial relationship between your organisation and any franchisee. In particular does your organisation rely financially on any other organisations within the group? |
|       |
| Do you share a brand name with other organisations?If ‘Yes’, what is the financial relationship between your organisation and other organisations within the brand, in particular does your organisation rely financially on any other organisations within the brand? |
|       |

**Unless you intend to be in full time day to day charge of the regulated activity you will need to submit a registered manager application. Please see our website** [**here**](http://www.cqc.org.uk/content/apply-new-registered-manager)**.**

**Please proceed to** [**section 4**](#Further) **to continue completing your application.****Section 3: Where the applicant is a partnership**

**If you are NOT applying as a partnership please go to** [**section 1**](#Section1) **(organisation) or**[**section 2**](#Section2) **(individual) as appropriate**

|  |
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| **\*3.1 The partnership’s name and contact details** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp20) |
| \*The partnership’s name |       |
| Name you trade under if different to the above |       |
| The principal office address of the partnership: |
| \*Address line 1 |       |
| \*Address line 2  |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| Website |       |
| \*Business telephone |       |
| Mobile telephone |       |
| Each partner will be required to provide proof of identity as part of this application, this must include a recent photo. **DO NOT** send this with your application, you will be asked to provide this information during the assessment of your application. By submitting this application you are confirming the partnership’s willingness for CQC to use the **email address** shown at 2.1 above for service of notices and other documents including draft and final inspection reports and for sending all other correspondence to it.If you **DO NOT** want to receive these by email please check or tick the box below. |
| We do **NOT** wish to receive notices and other documents including draft and final inspection reports and correspondence from CQC by email | [ ]  |  |

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| **3.2 Alternative temporary correspondence address** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp21) |
| Contact Name |       |
| Address line 1 |       |
| Address line 2  |       |
| Town/city |       |
| County |       | Postcode |       |
| Telephone |       |
| Email address |       |

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| **\*3.3 Is your partnership a franchise?** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp3) |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘No’, please go to Section 3.5If ‘Yes’, please provide the name and address franchisor |
| \*Name  |       |
| \*Property name (if any) |       |
| \*Business address line 1 |       |
| \*Business address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| Website |       |
| \*Business telephone number |       |
| \*Registered company number (if applicable) |       |
| \*Registered charity number (if applicable) |       |

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| **3.4 More information about franchisor**[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp4) |
| Please detail the financial relationship between your partnership and any franchisee. In particular does partnership rely financially on any other organisations within the group? |
|       |
| Do you share a brand name with other organisations?If ‘Yes’, what is the financial relationship between your partnership and other organisations within the brand, in particular does your organisation rely financially on any other organisations within the brand? |
|      ­­ |

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| **\*3.5 Main contact partner** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp22) |
| How many partners are there in your partnership? |     |  |
| Who will be the main partner to contact for CQC purposes? |
| \*Full name | Title       | First       | Middle       | Last       |
| Previous name (if applicable) |       |
| \*Date of Birth (dd/mm/yyyy) |       |

**The members of the partnership**

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| **The information below is for partner number:**This will be the main partner identified in Section 3.5 | **1** |  |

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| **\* First partner’s details**Sections 3.6 to 3.16 must be completed and signed by the partner named at Section 3.5. Where the partnership has more than two partners, each additional partner must fill in an additional partner section, which can be downloaded from the website page where you found this form. |
| **\*3.6 Partner’s contact details** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp23) |
| Your CQC ID number (If already registered) |       |
| \*Address line 1 |       |
| \*Address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| \*Business telephone  |       |
| Mobile telephone |       |

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| **\*3.7**  **Alternative temporary contact details for this application:** |
| **Do not complete this section if it is the same as the above address.****If you wish to provide an alternative temporary correspondence address we will only use this during your application period.** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp24) |
| Address line 1 |       |
| Address line 2 |       |
| Town/city |       |
| County |       | Postcode |       |
| Email |       |
| Telephone |       |
| **\*3.8 Previous history as a registered person** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp25) |
| Have you ever been registered as manager or provider of an establishment, agency or service registered under any of the following Acts of Parliament?(check / tick for yes, leave blank for no)If you have ever been registered as a manager, provider or nominated individual of an establishment, agency or service registered under any of the following Acts of Parliament. Has your registration ever been cancelled? If ‘yes’ please provide the reasons below. |
|  | The Registered Homes Act 1984 | [ ]  |  |
|  | The Registered Homes (Amendment) Act 1991 | [ ]  |  |
|  | The Children Act 1989 (including child-minding and day care for children) | [ ]  |  |
|  | The Nurses Agencies Act 1957 | [ ]  |  |
|  | The Care Standards Act 2000 | [ ]  |  |
|  | Health and Social Care Act 2008 | [ ]  |  |
| If you have answered ‘Yes’ to any of the above, please include details in section 3.9 |
| If you have ever been registered as a manager, provider or nominated individual of an establishment, agency or service registered under any of the following Acts of Parliament. Has your registration ever been cancelled? If ‘yes’ please provide the reasons below. |
|       |

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| **\* 3.9 Employment History (including previous history as a registered person)** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp12)Please provide details of your full employment history, if applicable please indicate where you were a registered person and the dates you were registered.* Please say why you left each post.
* Please explain any gaps in employment.

Please show dates in the format dd/mm/yyyy. |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |

|  |
| --- |
| Reasons for gaps in employment- (including dates to and from) |
|       |

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| **\*3.10**  **Medical history** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp27) |
| Do you have any physical or mental health conditions which are relevant to your ability to carry on the regulated activities in this application for registration? |
| Yes | [ ]  |  No | [ ]  |  |
|  |
| If you answered ‘Yes’, please provide details below Please describe any arrangements you or the partnership have put in place, including any reasonable adjustments, to enable you todo your job. |
|       |
| **Please note:** **You should tell CQC of any significant changes to your health after you are registered.** |

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| **\*3.11**  **Your GP** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp28) |
| We may need to contact your doctor about your application. Please supply their contact details below. |
| \*GP’s name | Title       | First       | Middle       | Last       |
| \*Surgery name |       |
| \*Address line 1  |       |
| \*Address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*I give permission for the Care Quality Commission to contact my doctor or their surgery. |
| Yes | [ ]  | No | [ ]  |  |

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| **\*3.12**  **Qualifications, skills and experience** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp29) |
| Please give details of any qualifications, skills and experience you have in relation to the regulated activities the partnership is applying to be registered for. |
|       |

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| **\*3.13**  **Declarations by a health or social care professional** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp30) |
| Professional Body Name |       |
| Professional Registration number |       |
| Professional Body Name |       |
| Professional Registration number |       |
| Are you currently the subject of, or have you ever been subject of any investigation, or proceedings by any professional body with regulatory functions in relation to health or social care professionals (including by a regulatory body in another country)? |
| Yes | [ ]  | No | [ ]  |  |
| If ‘Yes’, please provide details below. |
|       |
| Are you currently the subject of, or have you ever been subject of any safeguarding investigation?  |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes’, please provide details below. |
|       |
| Have you ever been disqualified from the practice of a profession or required to practice subject to specified limitations following a fitness to practice investigation by a regulatory body in the UK or another country? |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes’, please provide details below. |
|       |

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| --- |
| **\*3.14 Disclosure and Barring Service criminal records disclosure** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp31) |
| In the last 12 months, have you either:Applied for and received an **enhanced** DBS disclosure, that was **countersigned by CQC? (Please provide your most recent disclosure number)** |
| Yes | [ ]  | No | [ ]  |  |
| OrHave obtained an enhanced DBS disclosure through membership of a professional body ([see the list on the CQC website](https://www.cqc.org.uk/guidance-providers/registration/dbs-checks-cqc-registration)), and have posted the original DBS certificate to CQC |
| Yes | [ ]  | No | [ ]  |  |
|  |
| NB. If you have not done so, we will return your application |
| DBS disclosure number |       |
| Date of disclosure (dd/mm/yyyy) |       |

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| --- |
| **\*3.15 Reference** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp32) |
| We will need to contact a referee about your application. Please supply their contact details below.Your referee must be your last employer. If you do not have a last employer, your referee:* Must not be related to you.
* Must be able to provide a reference as to your competence and suitability to provide the service as a partner in the partnership.
 |
| \*Referee’s name | Title       | First       | Middle       | Last       |
| \*Address line 1  |       |
| \*Address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| \*Telephone no. |       |
| \*I give permission for the Care Quality Commission to contact my referee. |
| Yes | [ ]  | No | [ ]  |  |

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| **\*3.16 Partner’s signature** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp33)If you are submitting this form electronically we will accept a typed-in name as your signature.  |
| \*Signature of person at Section 3.6  |       |
| \* Partner’s full name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |

**The members of the partnership**

|  |  |  |
| --- | --- | --- |
| **The information below is for partner number:** | **2** |  |

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| **\* Second partner’s details**Sections 3.6 to 3.16 must be filled in and signed by the partner named at 3.6 below. Where the partnership has more than two partners each additional partner must fill in an additional partner section, which can be downloaded from the website page where you found this form. |
| **\*3.6 Partner’s name and contact details** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp23) |
| \*Full name | Title       | First       | Middle       | Last       |
| Previous name (if applicable) |       |
| \*Date of Birth (dd/mm/yyyy) |       |
| Your CQC ID number (If already registered) |       |
| \*Address line 1 |       |
| \*Address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| \*Business telephone  |       |
| Mobile telephone |       |

|  |
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| **\*3.7 Alternative temporary contact details for this application:** |
| **Do not complete this section if it is the same as the above address.****If you wish to provide an alternative temporary correspondence address we will only use this during your application period.** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp24) |
| Address line 1 |       |
| Address line 2 |       |
| Town/city |       |
| County |       | Postcode |       |
| Email |       |
| Telephone |       |
| **\*3.8 Previous history as a registered person** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp25) |
| Have you ever been registered as manager or provider of an establishment, agency or service registered under any of the following Acts of Parliament?(check / tick for yes, leave blank for no)If you have ever been registered as a manager, provider or nominated individual of an establishment, agency or service registered under any of the following Acts of Parliament. Has your registration ever been cancelled? If ‘yes’ please provide the reasons below. |
|  | The Registered Homes Act 1984 | [ ]  |  |
|  | The Registered Homes (Amendment) Act 1991 | [ ]  |  |
|  | The Children Act 1989 (including child-minding and day care for children) | [ ]  |  |
|  | The Nurses Agencies Act 1957 | [ ]  |  |
|  | The Care Standards Act 2000 | [ ]  |  |
|  | Health and Social Care Act 2008 | [ ]  |  |
| If you have answered ‘Yes’ to any of the above, please include details in section 3.9 below.  |
| If you have ever been registered as a manager, provider or nominated individual of an establishment, agency or service registered under any of the following Acts of Parliament. Has your registration ever been cancelled? If ‘yes’ please provide the reasons below. |
|       |

|  |
| --- |
| **\* 3.9 Employment History (including previous history as a registered person)** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp12)Please provide details of your full employment history, if applicable please indicate where you were a registered person* Please say why you left each post.
* Please explain any gaps in employment.

Please show dates in the format dd/mm/yyyy. |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |
| Start date |       | End date |       | Employer |       |
| Job title and brief description  |       |
| Reasons for leaving |       |
| Registered person (check/tick for ‘Yes’, leave blank for ‘No’)  |  [ ]  |
| Dates of registration:  | From:       | To:      |

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| --- |
| Reasons for gaps in employment |
|       |

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| **\*3.10 Medical history** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp27) |
| Do you have any physical or mental health conditions which are relevant to your ability to carry on the regulated activities in this application for registration? |
| Yes | [ ]  |  No | [ ]  |  |
|  |
| If you answered ‘Yes’, please provide details below Please describe any arrangements you or the partnership have put in place, including any reasonable adjustments, to enable you todo your job. |
|       |
| **Please note:** **You should tell CQC of any significant changes to your health after you are registered.** |

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| **\*3.11 Your GP** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp28) |
| We may need to contact your doctor about your application. Please supply their contact details below. |
| \*GP’s name | Title       | First       | Middle       | Last       |
| \*Surgery name |       |
| \*Address line 1  |       |
| \*Address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*I give permission for the Care Quality Commission to contact my doctor or their surgery. |
| Yes | [ ]  | No | [ ]  |  |

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| **\*3.12 Qualifications, skills and experience** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp29) |
| Please give details of any qualifications, skills and experience you have in relation to the regulated activities the partnership is applying to be registered for. |
|       |

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| **\*3.13 Declarations by a health or social care professional** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp30) |
| Professional Body Name |       |
| Professional Registration number |       |
| Professional Body Name |       |
| Professional Registration number |       |
| Are you currently the subject of, or have you ever been subject of any investigation, or proceedings by any professional body with regulatory functions in relation to health or social care professionals (including by a regulatory body in another country)? |
| Yes | [ ]  | No | [ ]  |  |
| If ‘Yes’, please provide details below. |
|       |
| Are you currently the subject of, or have you ever been subject of any safeguarding investigation?  |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes’, please provide details below. |
|       |
| Have you ever been disqualified from the practice of a profession or required to practice subject to specified limitations following a fitness to practice investigation by a regulatory body in the UK or another country? |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes’, please provide details below. |
|       |

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| **\*3.14 Disclosure and Barring Service criminal records disclosure** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp31) |
| Have you applied for and received an **enhanced** DBS disclosure within the last 12 months, and was the application for the disclosure **countersigned by CQC? (Please provide your most recent disclosure number)** |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If you have not done so, we will return your application |
| DBS disclosure number |       |
| Date of disclosure (dd/mm/yyyy) |       |

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| **\*3.15 Reference** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp32) |
| We will need to contact a referee about your application. Please supply their contact details below.Your referee must be your last employer. If you do not have a last employer, your referee:* Must not be related to you.
* Must be able to provide a reference as to your competence and suitability to provide the service as a partner in the partnership.
 |
| \*Referee’s name | Title       | First       | Middle       | Last       |
| \*Address line 1  |       |
| \*Address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Email address |       |
| \*Telephone no. |       |
| \*I give permission for the Care Quality Commission to contact my referee. |
| Yes | [ ]  | No | [ ]  |  |

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| **\*3.16 Partner’s signature** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp33)If you are submitting this form electronically we will accept a typed-in name as your signature.  |
| \*Signature of person at Section 3.6  |       |
| \*Partner’s full name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |

**You will need to submit a registered manager application. Please see our website** [**here**](http://www.cqc.org.uk/content/apply-new-registered-manager)**.**

**Please proceed to** [**section 4**](#Further) **to continue completing your application.****Section 4: Financial information**

**(To be completed by all applicants)**

|  |
| --- |
| **4.1 Invoice and financial contact details** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp45) |
| Name | Title       | First       | Middle       | Last       |
| Role / job title |       |
| Business address line 1 |       |
| Business address line 2 |       |
| Town/city |       |
| County |       | Postcode |       |
| Business telephone |       |
| Mobile telephone |       |
| Email address |       |

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| **\*4.2 Administration, receivership, and other insolvency processes** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp46) |
| **Organisation application:** Has either the company or any holding or parent company ever been in administration, receivership, or subject to any other insolvency processes, resolved or otherwise? **Organisation application:** Have any of the members of the board or equivalent at section 1.5 above ever been declared bankrupt or subject to any other insolvency process or proceedings resolved or otherwise?**Partnership and individual application:** Have you (or any member of the partnership) ever been declared bankrupt or have been subject to any other insolvency processes or proceedings resolved or otherwise? Have you or any member of the partnership ever been a director or equivalent in an organisation or partner in a partnership that went into administration or was subject to any other insolvency processes or proceedings, resolved or otherwise? Please answer “yes” or “no” if any of the statements above applies to you. |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes’, please give details: |
|       |

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| **\*4.3 Financial interests in registered services** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp47) |
| **Organisation:** Does your organisation have any current financial or business interests in a registered provider? Or does another registered provider have any financial or business interests in your organisation?**Partnership or individual:** Do you as an individual or any member of the partnership have any current financial or business interests in a registered provider?Please answer “yes” or “no” if either of the statements above applies to you.  |
| Yes | [ ]  | No | [ ]  |  |
| If ‘Yes’, please provide details of the other service(s). |
|       |

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| **\*4.4 Essential business relationships with other service providers** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp48) |
| Will your carrying on of the regulated activities proposed in this application depend upon formal contractual relationships with any other service provider? |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes’, please provide details of the other provider(s) and the nature of the dependence. |
|       |

**Section 5: The regulated activity/activities you want to provide**

**(To be completed by all applicants)**

|  |
| --- |
| Please check / tick the regulated activities you are applying to provide across all of the locations in this application.[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp49) |
| Personal care – (RA1) | [ ]  |  |
| Accommodation for persons who require nursing or personal care – (RA2)(Please also see Section 3.12 in each location section if you have checked/ticked this activity) | [ ]  |  |
| Accommodation for persons who require treatment for substance misuse – (RA3) | [ ]  |  |
| Treatment of disease, disorder or injury – (RA5) | [ ]  |  |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 – (RA6) | [ ]  |  |
| Surgical procedures – (RA7) | [ ]  |  |
| Diagnostic and screening procedures – (RA8) | [ ]  |  |
| Management of supply of blood and blood derived products – (RA9) | [ ]  |  |
| Transport services, triage and medical advice provided remotely - (RA10) | [ ]  |  |
| Maternity and midwifery services – (RA11) | [ ]  |  |
| Termination of pregnancies – (RA12) | [ ]  |  |
| Services in slimming clinics – (RA13) | [ ]  |  |
| Nursing care – (RA14) | [ ]  |  |
| Family planning service - (RA15) | [ ]  |  |

**Section 6: The locations you want to provide regulated activity/activities at or from (To be completed by all applicants)**

|  |
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| **\*6.1 Purchase or transfer of existing location(s)** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp50) |
| Does this application involve the purchase or transfer of location(s) being used to provide some or all of the regulated activities you selected in Section 5 above by an existing provider that is already registered under the Health and Social Care Act 2008 (as amended)? |
| Yes | [ ]  | No | [ ]  |  |
|  |
| If ‘Yes', please fill in the details of the existing registered provider below: |
| \*CQC provider name |       |
| CQC provider ID |       |
| \*Business telephone |       |
| \*Email address  |       |
| CQC may need to contact the existing provider regarding this application. Please tick if you do **not** wish CQC to contact the existing provider regarding this application. | [ ]  |  |

**\*6.2 Location details** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp51)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details for Location number:** | **1** | **of:** |  | **locations** |
| CQC Location ID (if already registered) |       |
| \*Name of location |       |
| \*Location address line 1 |       |
| \*Location address line 2 |       |
| \*Town/city |       |
| County |       | \*Postcode |       |
| \*Business telephone |       |
| No of places or beds (\*if applicable) |       |
| \*Email |       |
| Website |       |

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| **\*6.3 Planning consent** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp52) |
| Does this location have planning consent to provide the regulated activity(s) you intend to carry on there? |
| Yes | [ ]  | No | [ ]  | Not applicable | [ ]  |  |
| T |
| Local authority |       | Date of consent (dd/mm/yyyy) |       |  |
|  |
| Where you have indicated **no** or **not applicable** and you do not have planning consent, please explain why it is not needed or why it is not yet received? |
|       |

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| **\*6.4 Building regulations** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp53) |
| Is there Building Regulations approval for any applicable building works undertaken at this location? |
| Yes | [ ]  | No | [ ]  | Not applicable | [ ]  |  |
|  |
| Where you have indicated **no** or **not applicable** and the relevant Building Regulations Certificates have yet to be issued, please tell us when you expect to receive them? |
|       |

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| **\*6.5 Food safety** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp54) |
| If you will provide food to the people who use your service at or from this location, have you registered with the relevant local council’s Environmental Health Department as a food business? |
| Yes | [ ]  | No | [ ]  | Not applicable | [ ]  |  |
| Where you have **not registered** with the Environmental Health Department or if you have indicated this is **not applicable** please explain why. |
|       |

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| **\*6.6 Safety of equipment, plant and utilities** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp55) |
| Do you have maintenance contracts in relation to all the equipment, plant and utilities you own, lease or use – or will own, lease or use – in relation to providing your service at this location? |
| Yes | [ ]  | No | [ ]  | Not applicable | [ ]  |  |
|  |
| If ‘**No**’, please describe the equipment, plant and utilities not covered by maintenance contracts and how you will ensure that servicing and repairs are undertaken in a timely and prompt way, as required by their manufacturer’s instructions. |
|       |

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| **\*6.7 Landlord/Mortgage lender permission** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp56) |
| Where you do not own this location, do you have your landlord’s written permission to use it to carry on the regulated activity(s) you intend to provide there?Where you do not own this location and you have a mortgage, do you have the mortgage lender’s written permission to use it to carry on the regulated activity(s) you intend to provide there?  |
| Yes | [ ]  | No | [ ]  | Not applicable | [ ]  |  |
|  |
| If **No** and you do not have your landlord’s or mortgage lender’s permission, please explain why it is not needed or not yet received? |
|       |

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| **\*6.8 Location readiness** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp57) |
| You cannot carry on a regulated activity at or from a location until you can meet the requirements of the Health and Social Care Act 2008 (as amended) and associated regulations at or from that location. |
| What date will the location be ready (dd/mm/yyyy)? |       |  |

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| **\*6.9 The regulated activities you propose to carry on at this location** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp58) |
| **You cannot apply to carry on regulated activities at this location that are not also checked / ticked in Section 5.** |
| Personal care  | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Accommodation for persons who require nursing or personal care | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Accommodation for persons who require treatment for substance misuse | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Treatment of disease, disorder or injury | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983  | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Surgical procedures | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Diagnostic and screening procedures | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Management of supply of blood and blood-derived products  | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Transport services, triage and medical advice provided remotely | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Maternity and midwifery services | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Termination of pregnancies | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Services in slimming clinics | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Nursing care | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |
| Family planning services | [ ]  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location.      |

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| **\*6.10 The service types provided at this location** [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp59) |
| **Before you complete this section, you are strongly advised to read the ‘Guidance for providers on meeting the regulations’.****The service type(s) you select are used to calculate your annual fee, so it is important to select only those that apply to each of the locations you are registering**.**You should also read our guidance for providers about fees before completing this section.** These guidance documents are available on our website. |

|  |
| --- |
| **Healthcare services** |
| **Acute services (ACS)**If you have checked/ticked this service type, but the only or main activity provided at this location is one of those listed below, please **also check/tick the relevant box**.If you provide other services at this location as well as Acute services (ACS), or more than one of the activities below at this location, **do not check/tick the boxes below.**

|  |  |
| --- | --- |
| (a) Haemodialysis or peritoneal dialysis | [ ]  |
| (b) Dental treatment carried out under general anaesthesia | [ ]  |
| (c) The termination of pregnancies | [ ]  |
| (d) Hyperbaric therapy | [ ]  |
| (e) Refractive eye surgery | [ ]  |
| (f) Surgical procedures associated with in vitro fertilisation or assisted conception  | [ ]  |
| (g) Obstetric services and, in connection with childbirth, medical services | [ ]  |
| (h) Cosmetic surgery  | [ ]  |
| (i) Acute services, where the location has no overnight beds for patients | [ ]  |

 | [ ]  |
| **Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)**  | [ ]  |
| **Rehabilitation services (RHS)** | [ ]  |
| **Hyperbaric chamber services (HBC)** | [ ]  |
| **Hospice services (HPS)**If you have ticked this service type, please **also** complete **one** of the following questions only:

|  |  |
| --- | --- |
| (a) Does your hospice service provide overnight beds for patients?(Please complete even if your service also includes community or outreach services.)  | [ ]  |
| (b) Does your service provide hospice at home services or end of life or respite care for people in the community?  | [ ]  |

  | [ ]  |
| **Long-term conditions services (LTC)** | [ ]  |
| **Prison health care services (PHS)** | [ ]  |
| **Residential substance misuse treatment/rehabilitation services (RSM)** | [ ]  |
| **Community or integrated healthcare** |
| **Community health care services (CHC)** Please also tick if you are a nursing agency only | [ ]  |
| **Doctors consultation services (DCS)** | [ ]  |
| **Doctors treatment services (DTS)** | [ ]  |
| **Dental services (DEN)**If this is a single location only please also complete the following question.

|  |  |
| --- | --- |
| Please state the number of dental chairs at this location(State ‘0’ if you are a domiciliary dental provider and have no dental chairs of your own) |  |

**Do not complete this question if you are applying to carry on activities at or from more than one location.** | [ ]  |
| **Diagnostic and/or screening services (DSS)**You should **ONLY** tick this service type if diagnostic and/or screening services are the only or main activity you provide at this location. If you provide other services at this location, you should not select this service type, even if you provide the regulated activity of Diagnostic and screening procedures.**If you have selected DSS, please also complete the following questions:**

|  |  |
| --- | --- |
| (a) If you are registering as an organisation or a partnership and provide diagnostic and screening services as your sole or main activity, please check/tick this box | [ ]  |
| (b) If you are registering as an individual, for the regulated activity of Diagnostic and screening procedures ONLY, AND are registering for one location ONLY, please check/tick this box | [ ]  |

 | [ ]  |
| **Community-based services for people with a learning disability (LDC)** | [ ]  |
| **Mobile doctors services (MBS)** | [ ]  |
| **Community-based services for people with mental health needs (MHC)** | [ ]  |
| **Community-based services for people who misuse substances (SMC)** | [ ]  |
| **Urgent care services (UCS)** | [ ]  |
| **Residential social care** |
| **Specialist college service (SPC)** | [ ]  |
| **Care home service with nursing (CHN)** | [ ]  |
| **Care home service without nursing (CHS)** | [ ]  |
| **Community social care** |
| **Domiciliary care service (DCC)** | [ ]  |
| **Extra Care housing services (EXC)** | [ ]  |
| **Shared Lives (SHL)** | [ ]  |
| **Supported living service (SLS)** | [ ]  |
| **Miscellaneous healthcare** |
| **Ambulance services (AMB)** | [ ]  |
| **Blood and transplant services (BTS)** | [ ]  |
| **Remote clinical advice services (RCA)** | [ ]  |

|  |
| --- |
| **For Primary Medical Service providers only**Please select what type of location this is. |
| **NHS GP practice** | [ ]  |
| **NHS out-of-hours service** | [ ]  |
| **Urgent care centre** | [ ]  |
| **Minor injury unit** | [ ]  |
| **Walk-in centre** | [ ]  |
| **Other** | [ ]  |
|  |
| **Please check/tick the box if you are a dispensing practice** | [ ]  |

|  |
| --- |
| **6.11 Condition of registration about the number of persons accommodated to receive nursing or personal care at this location** |
| [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp60)Only check or tick the box in this section if you checked / ticked the regulated activity‘ Accommodation for persons who require nursing or personal care’ at Section 6.9 above and either the service type ‘Care home service without nursing’ or ‘Care home service with nursing’ at Section 6.10 above**. If this does not apply to you go straight to Section 6.13 below.**Please check / tick the box below to confirm that you are agreeing in writing to a condition of registration that says**“The number of persons accommodated to receive nursing or personal care at this location must not exceed [number].”**The number in this condition will normally be the one you filled in at Section 6.2 above (number of places or beds). We will contact you if we decide we cannot agree to your proposed number for this condition. |
| We agree in writing to the condition of registration shown above, using the number of places or beds we proposed in section 6.2 of this form | [ ]  |  |

|  |
| --- |
| **6.12 Condition of registration about not providing nursing care at this location** |
| [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp61)Only check / tick the box below if you checked / ticked the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 6.9 above **AND the service type** ‘Care home service without nursing (CHS)’ at Section 6.10 above (If this does not apply to you please go to Section 6.13 below).Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says **“The provider must not provide nursing care under the accommodation for persons who require nursing or personal care regulated activity at this location.”** |
| We agree in writing to the condition of registration shown above | [ ]  |  |

|  |
| --- |
| **\*6.13 Condition of registration about the regulated activity (or activities) at this and other locations** |
| [**(See Guidance)**](http://www.cqc.org.uk/applicationhelp62)Please check / tick below to confirm that you are agreeing in writing to a condition of registration in respect of each regulated activity that says **“This Regulated Activity may only be carried on at or from the following locations:****<First location>****<Second location> (if there is one)****(and so on for any more locations)”**The locations in this condition will be those specified in each Section 6 submitted with this application. The regulated activities will be the ones you specified in each Section 6.9. |
| We agree in writing to the condition of registration shown above | [ ]  |  |

|  |
| --- |
| **\*6.14 Service user bands** |
| Please look at our [**guidance on service user bands**](https://www.cqc.org.uk/guidance-providers/registration/service-user-bands) before you complete this section.Please check or tick **all** of the descriptions / service user bands for the people that will use this location. If you will provide a service to everyone you can check or tick ‘The whole population’. |
| **Age groups** |
| Whole population | Children0 to 3 | Children4 to 12 | Children13 to 17 | Adults18 to 65 | Adults65 + |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Service user band** |
| Dementia | [ ]  | People detained under the Mental Health Act | [ ]  |
| Mental health | [ ]  | People who misuse drugs or alcohol | [ ]  |
| People with an eating disorder | [ ]  | Sensory impairment | [ ]  |
| Learning difficulties or autistic spectrum disorder | [ ]  | Physical disability | [ ]  |

|  |
| --- |
| **\*6.15** **Condition of registration about providing a specialist service to people with a learning disability or people with a learning disability and autism.** |
| [(See Guidance on agreeing to routine conditions)](http://www.cqc.org.uk/applicationhelp62)**This section only applies if you:** * have applied for **ANY** of the following regulated activities:
	+ Accommodation for persons who require nursing or personal care
	+ Personal care
	+ Assessment or medical treatment for persons detained under the Mental Health Act 1983

**AND*** have **NOT** selected the service user band of Learning disability or autistic spectrum disorder in section 6.14 above.

**If this does not apply to you, go straight to section 7 below.**If this location will provide community or residential adult social care services:Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:**‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for care or support is as a direct result of the person’s learning disability and or autism at or from [this location].’**If this location will provide in-patient mental health services:Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:**‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for assessment or treatment is as a direct result of the person’s learning disability and or autism at or from [this location].’**Note: We are adding this condition because you will not be providing a specialist service to people with a learning disability or autistic people. Because of this we will not assess your ability to deliver a service in line with [**Right support, right care, right culture**](https://www.cqc.org.uk/guidance-providers/autistic-people-learning-disability/right-support-right-care-right-culture). If want to provide a specialist service to people with a learning disability or autistic people in the future, you can apply to remove the condition. We must approve your application before you start providing the service. |
| We agree in writing to the condition of registration shown above | [ ]  |  |

**Important**: Please note if you have not agreed to the condition above because you are intending to provide a specialist service to people with a learning disability and autistic people you will also need to submit an [additional form](https://www.cqc.org.uk/sites/default/files/2022-06/20220504_additional_form_for_providers_of_services_for_autistic_people_and_people_with_%20learning_disabilities.docx) to support your application process.

**\*Section 7: How you will provide your service**

**(To be completed by all applicants)**

[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp70)

You must complete each of the five parts of this section of the application. If you do not complete each part we will return your application to you. In answering these five key questions you would be demonstrating how the requirements of the Health and Social Care Act 2008 and associated regulations will be met. In particular the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) (the ‘2014 Regulations’) and the Care Quality Commission (Registration) Regulations 2009 (as amended) (the ‘2009 Regulations’)

|  |
| --- |
| **\*7.1 Please describe how you will ensure your service is safe**  |
|       |
| **\*7.2 Please describe how you will ensure your service is effective** |
|       |
| **\*7.3 Please describe how you will ensure your service is caring** |
|       |
| **\*7.4 Please describe how you will ensure your service is responsive** |
|       |
| **\*7.5 Please describe how you will ensure your service is well-led** |
|       |

**\*Section 8: Checklist of information that must be available to CQC on request** **(To be completed by all applicants)**

[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp71)

|  |
| --- |
| The full list of supporting documents you **must** submit with your application can be accessed through the following link: [Supporting documents: provider registration application - Care Quality Commission](https://www.cqc.org.uk/guidance-regulation/providers/registration/supporting-documents-provider)\*Please confirm that the following information is available in relation to each of the regulated activities you propose to provide, if required by CQC.You **do not** need to submit this additional information with your application. We will ask to see it if we need to.(Check / tick to show that the information is available.) |
| Staffing details and personnel records | [ ]  |  |
| Staffing rotas (if applicable) | [ ]  |  |
| Contract arrangements for equipment and services necessary | [ ]  |  |
| Confirmation that where planning permission or buildings approval is required, it has been obtained | [ ]  |  |

**Section 9: Partnerships only - Agreement to conditions of registration**

|  |
| --- |
| CQC routinely agrees conditions of registration with providers about the membership of partnerships and the locations where regulated activities will be carried on, at or from. These conditions are called the ‘partnership condition’ and the ‘location condition’. There is more information about this in guidance you can read on our website.The partnership condition enables partnerships to continue as the same legal entity when partners leave and join. Partnerships need only submit an application to vary the condition to add or remove partners rather than have to apply to register again as a completely new provider. CQC assesses the fitness of any new partners and the continuing fitness of the partnership as part of this.The wording of the **partnership condition** is as follows:“It is a condition of registration (in respect of the regulated activities that you are applying to provide) that the membership of the partnership is as follows:<First partner’s name><Second partner’s name>(and so on for any more partners)”Please check / tick below to confirm that you are agreeing in writing to this condition of registration. |
| We agree in writing to the conditions of registration shown above | [ ]  |  |

# Section 10: Supporting notes

[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp72)

|  |
| --- |
| Please use this space to provide any additional information needed to support your answers to any of the questions in this section. |
|       |

#

# \*Section 11: Application declaration [(See Guidance)](http://www.cqc.org.uk/applicationhelp73)

**PLEASE READ THE DECLARATION CAREFULLY BEFORE SIGNING**

This declaration MUST be signed by the following:

**If the applicant is an Organisation:** An individual duly authorised by the Organisation to sign the declaration.

**If the applicant is a Partnership:** All partners must sign this declaration

**If the applicant is an Individual:** The individual.

|  |
| --- |
| I/We hereby declare that the information detailed in this application is true and accurate.I/We understand that Section 37 of the Act makes it an offence to knowingly make a statement which is false or misleading in a material respect in this application. This will apply to the entirety of the application. I/We understand that to knowingly make a false or misleading statement could render us liable to prosecution. It could also lead to the refusal of this application or if the false or misleading statement becomes apparent after registration is granted, it could result in cancellation of registration. I/We understand that it is our responsibility to inform the CQC of any information that is relevant to our application which may not have been requested, and to update CQC with this information accordingly. I/We have kept a copy of all the information submitted and will keep a copy of anything we submit subsequently.I/We understand that if I/we change our postal or email address for service of notices documents and other communications, I/we must update the relevant part of our Statement of Purpose, notify CQC about the change and supply a copy of the amended Statement in accordance with Regulation 12 of, and schedule 3, to the 2009 Regulations.I/We understand if this application is granted I/we will be legally obliged to meet the Act and associated regulations, in particular the 2014 Regulations and 2009 Regulations and to have regard to the ‘Guidance about the Regulations for Providers’. I/We understand that failing to meet the relevant legislation could lead to the refusal of this application.Once registered, I/we agree to inform CQC if I/we can no longer meet the regulations. Failing to meet the regulations once registered could result in civil or criminal enforcement action being taken. By submitting this application I/we agree that the information contained in this form may be used to form conditions of registration. |

|  |  |
| --- | --- |
| Please check or tick this box to confirm that the appropriate number of registered managers have also submitted applications for registration | [ ]  |

|  |  |
| --- | --- |
| If this is an organisation application please check or tick this box to confirm that the organisation’s directors or equivalent have seen and agreed the contents of this application | [ ]  |

If you are submitting this form electronically we will accept a typed-in name as a signature.

|  |  |
| --- | --- |
| \*Applicant’s signature |       |
| \*Applicant’s name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |
| \*Role / job title |       |
| \*Email address |       |

|  |  |
| --- | --- |
| \*Partner’s signature |       |
| \*Partners name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |
| \*Partner’s signature |       |
| \*Partners name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |
| \*Partner’s signature |       |
| \*Partners name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |
| \*Partner’s signature |       |
| \*Partners name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |
| \*Partner’s signature |       |
| \*Partners name | Title       | First       | Middle       | Last       |
| \*Date of signing (dd/mm/yyyy) |       |

**How to submit this application and accompanying documents**

[**(See Guidance)**](http://www.cqc.org.uk/applicationhelp74)

Please submit this application to the Care Quality Commission, making sure that all required additional forms and documents are included.

**The checklist below lists the documents that you need to include with the application:**

|  |  |
| --- | --- |
| Form or document | Done |
| Statement of purpose (A template is available on our website for you to use if you prefer)  | [ ]  |
| Additional nominated individual sections as needed | Number of nominated individuals in the organisation |  |  | [ ]  |
|     |
|  |
| Number of additional nominated individual sections submitted with this application |  |  |
|     |
|  |
| Additional location sections as needed | Number of locations where we are applying to carry on regulated activities |  |  | [ ]  |
|     |
|  |
| Number of additional location sections submitted with this application |  |  |
|     |
|  |
| Registered manager application forms | Number of locations in this application that will have a registered manager |  |  | [ ]  |
|     |
|  |
| Number of manager application forms of all types submitted with this application |  |  |
|     |
|  |

## Where to send the application:

Please email your completed form(s) and accompanying documents to: HSCA\_Applications@cqc.org.uk

You must attach all the forms and documents to the same email.

If you do not submit all required forms and information your application will have to be returned to you.

You can read more information on our website [www.cqc.org.uk](http://www.cqc.org.uk) or call our National Customer Service Centre on **03000 616161**.

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