

ORAL, MAXILLOFACIAL, HEAD OR NECK SURGERY SUPPLEMENTARY QUESTIONNAIRE

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

1.1 Please state whether you are employed by the NHS as a Consultant Oral Maxillofacial Surgeon: Yes No

1.2 Please state whether you have a sub-specialty interest: Yes No

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

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

Sub-specialty	Private Practice	NHS
Cosmetic surgery:		
Craniofacial and cleft surgery:		
Craniofacial trauma:		
Oral and maxillofacial (including implants):		
Oral medicine:		
Orthognathic surgery:		
Surgery of head and neck cancer:		
Temperomandibular surgery:		
Uvulopalatopharyngoplasty:		
Other:		
Total:		

If other, please provide full details:

1.4 Please state whether you perform any corrective craniofacial surgery on children in Private Practice Yes No

If yes, please state how many children you performed corrective craniofacial surgery on during the last year in Private Practice and the NHS:

Type of procedure	Private Practice	NHS

1.5 Please state whether you perform any facial plastic surgery:

Yes

No

If yes:

a) please state the plastic surgery associations of which you are a member:

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b) please provide a breakdown of the number of procedures you performed during the last year in Private Practice and the NHS:

Surgical procedure	Private Practice	NHS
Blepharoplasty (cosmetic) - lower:		
Blepharoplasty (cosmetic) - upper:		
Facelifts (including full, short scar and brow lift):		
Neck:		
Otoplasty:		
Rhinoplasty:		
Other:		

If other, please provide full details:

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1.6 Please state whether you perform any aesthetic procedures in Private Practice:

Yes

No

If yes, please provide a breakdown of the number of procedures you performed during the last year and the products used:

Aesthetic treatment	Number of procedures	Product used
Botox - face:		
Botox - platysmal bands:		
Fillers - temporary:		
Fillers - semi permanent:		
Fillers - permanent:		
Other:		
Total:		

If other, please provide full details:

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

Yes

No

If yes, please provide full details.

DECLARATION

I declare that:

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

Signed: _____ Full name: _____

Date: _____ DD / MM / YY

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