

Health Information and Quality Authority

Personal Information Form¹

Designated Centre – Special Care Unit (DCSC)



Section 1. Designated centre details

Centre name

Centre ID (OSV)

Section 2. Contact details for the person

Please tick the relevant role

Person in charge (PIC)

☐

Person participating in management (PPIM)

☐

Title

Ms ☐ Miss ☐ Mrs ☐ Mr ☐ Other ☐ ____

First name

Surname

Job title

Start date
(current role)

¹ This form should be completed by the registered provider in respect of the person in charge and each person participating in management at the designated centre. Please enclose this form with your **registration pack** or **notification pack**, as applicable.

Section 2. Contact details for the person

Business phone number	
Business mobile number (optional)	
Business email address	

Section 3. Registration with a professional regulatory body

Professional body	Registration number	Registration status

Section 4. Qualifications

Please list **relevant** qualifications or accredited training for the person.

Name of qualification	Name of awarding body	Date of award

Section 5. Employment history

Please provide a **full** employment history, together with a satisfactory history of any gaps in employment, starting with the person's current role.

Start and end date	Employer/ organisation name and address	Job title and position details	Reason for leaving

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Section 6. Verification of previous employment

Has this person ever worked with vulnerable adults or children in a previous role?

Yes ☐ Please go to subsection 6.1

No ☐ Please go to section 7.

Subsection 6.1

Have you verified the reason why the employment or position(s) has ended for each period of employment?

Yes ☐ No ☐

If you ticked **no**, please provide details of why you have **not verified** the reason the person's employment or position(s) ended.

If you ticked **yes**, are you satisfied with the reasons given for why the employment or position ended?

Yes ☐ No ☐

If **no**, please provide details of why you are **not satisfied** with the reasons given for why the person's employment or position(s) ended.

Section 7. Details of previous experience

Has this person ever participated in the management of a special

Yes ☐ Please go to subsection 7.1

care unit or services registered with another regulator or social care sector in Ireland or in another state?

No ☐ Please go to section 8.

Subsection 7.1

Please list the designated centres which this person has participated in the management of, in Ireland or a similar service outside of Ireland.

Section 8. Declaration by the registered provider

I, the undersigned, having been authorised to do so, declare that the information I have provided in this form is true to the best of my knowledge and belief.

Name (print)	
Position	Person responsible on behalf of the statutory body <input type="checkbox"/>
Signed	
Date	
Contact number (during office hours)	

Please return this form with your **registration pack** or **notification pack** to:

Registration Office, Regulatory Support Services, Health Information and Quality Authority, Unit 1301, City Gate, Mahon, Cork, T12 Y2XT.

Telephone no: 021 240 9340

Email: registration@higa.ie