CLAIM FOR LOCUM PAYMENTS TO COVER MATERNITY, PATERNITY, ADOPTION AND SHARED PARENTAL LEAVE

Practices will need to complete an application form (LOC2A and LOC2C (if appropriate)) to obtain approval from their Local Health Board before claiming a payment. All the locums who work for the practice during the period covered by the claim must fill in and sign the certificate on the reverse of this form.

This is an interactive form which contains fields that allow to select or fill in, eliminating the need to print the form and complete by hand. Forms completed incorrectly or are not supported with satisfactory evidence will be returned and may result in a delay with your application.

PART A – DETAILS OF APPLICATION

Name of Performer Taking Leave: Click or tap here to enter text.

Practice Address: Click or tap here to enter text.

W-Code: Click or tap here to enter text.

GMC Number: Click or tap here to enter text.

Health Board: Choose an item.

Type of leave:

- ☐ Maternity
- ☐ Paternity
- ☐ Adoption
- ☐ Shared Parental
- ☐ Special Leave

Period of Claim from: Click or tap to enter a date.

Period of Claim to: Click or tap to enter a date.

Total amount claimed for period: £ Click or tap here to enter text.

PART B - DECLARATION OF PRACTICE APPLYING FOR PAYMENT

- I/We certify that the performer(s) shown on this form were actually and necessarily engaged by the practice to cover the absence of a performer because of maternity, paternity, adoption leave, shared parental or special leave.
- I/We confirm the performer(s) who worked for the practice during the period covered by this claim have filled in and signed the certificate overleaf and have included an invoice as evidence.
- I/We confirm that no other payment for locum cover in respect of maternity, paternity, adoption leave, shared parental or special leave is being claimed in respect of the performer on leave.
- I/we declare that the information on this form is correct and I/we apply for payment towards the cost of employing a locum in accordance with Part 4 of the Statement of Financial Entitlements.

Signature:

Designation: Click or tap here to enter text. Date: Click or tap to enter a date.

Please return to: nwssp-primarycareservices@wales.nhs.uk

PART C – CERTIFICATE TO BE COMPLETED BY ALL PERFORMERS

I Click or tap here to enter text. (please state name and designation), GMC Number Click or tap here to enter text., certify that I provided Locum cover at the practice named on page 1 of this form for the period:
Click or tap to enter a date. - Click or tap to enter a date.

I acknowledge receipt of £ Click or tap here to enter text. paid to me for my services as a Locum during this period (which excludes pension costs). I confirm that I was included in the relevant Performers List of a Health Board in Wales during the period stated above.

Locum type (as set out in Section 11 of the SFE). Please tick as appropriate:
☐ All Wales Locum Register ☐ Internal to the practice ☐ Other (exceptional circumstances*)

Signature:

Date: Click or tap to enter a date.

* Please attach supporting authorisation from the Health Board.

PART C – CERTIFICATE TO BE COMPLETED BY ALL PERFORMERS

I Click or tap here to enter text. (please state name and designation), GMC Number Click or tap here to enter text., certify that I provided Locum cover at the practice named on page 1 of this form for the period:
Click or tap to enter a date. - Click or tap to enter a date.

I acknowledge receipt of £ Click or tap here to enter text. paid to me for my services as a Locum during this period (which excludes pension costs). I confirm that I was included in the relevant Performers List of a Health Board in Wales during the period stated above.

Locum type (as set out in Section 11 of the SFE). Please tick as appropriate:
☐ All Wales Locum Register ☐ Internal to the practice ☐ Other (exceptional circumstances*)

Signature:

Date: Click or tap to enter a date.

I Click or tap here to enter text. (please state name and designation), GMC Number Click or tap here to enter text., certify that I provided Locum cover at the practice named on page 1 of this form for the period:
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Locum type (as set out in Section 11 of the SFE). Please tick as appropriate:
☐ All Wales Locum Register ☐ Internal to the practice ☐ Other (exceptional circumstances*)

Signature:

Date: Click or tap to enter a date.

* Please attach supporting authorisation from the Health Board.

PART D – TO BE COMPLETED BY CONTRACTS MANAGEMENT

Date received:

Application complete: ☐ Yes ☐ No

Application approved by Health Board: ☐Yes ☐ No

Any conditions on approval decision:

This claim for period: to

All GPs have been checked and are included on the Medical Performers List. ☐Yes ☐ No ☐N/A

Comments:

And/or:

All Independent Prescribers have been checked against the Independent Prescribers List and are included. ☐Yes ☐ No ☐N/A

Comments:

Processed by:

Date Processed:

* Please attach supporting authorisation from the Health Board.