The Registrar
Medical Council Malta
St. Luke's Hospital,
Outpatient' Department, Level 1,
Gwardamangia, PTA 1010.

To Whom It May Concern:

I the undersigned (*insert name)* Dr/Mr/Prof. _____ Medical Council Registration No. _____ declare that I have read Legal Notice 84 of 2014 of the Health Act, Chapter 528 of the Laws of Malta, "Indemnity Insurance for Healthcare Professionals Regulations" and the Frequently Asked Questions issued by the Medical Council Malta.

I therefore declare that from the month of _____ year _____ till the month of _____ year _____[1] *(please cross through where not applicable)*:

1) I am covered by a professional indemnity insurance policy, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose, which is appropriate to the nature and extent of the risk which I undertake when providing healthcare services to patients.

or

2) I am **not** covered by a professional indemnity insurance policy, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose, which is appropriate to the nature and extent of the risk which I undertake when providing healthcare services to patients, **since I do not practice my Medical / Dental Profession in Malta.**

I am therefore also declaring that I have complied with all the requirements as established by the "Indemnity Insurance for Healthcare Professionals Regulations" (L.N. 84 of 2014 under the Health Act, Chapter 528 of the Laws of Malta).

_____
(Name and Signature)
I.D.

_____
Date

** Please note that this form, which may be downloaded from our website, is to reach the Medical Council by the end of January of each year.*
** The Medical Council has drafted a set of Frequently Asked Questions (FAQs) for your guidance which may be accessed online or by sending a request by email at medicalcouncil@gov.mt*

[1] Please insert details as per insurance cover