

Notice of withdrawal from a Capitation/Continuing Care arrangement

An individual copy of this form must be completed for each patient who is the subject of a withdrawal from a Continuing Care or Capitation arrangement.

The dentist should study the two options available below and then complete the relevant section :-

Section One to cover withdrawal with immediate effect

OR

Section Two where three months notice of withdrawal has been given to the patient

NB. Failure to complete and submit this form will mean that the patient will continue to be registered with the dentist and as such the dentist will be required to meet their terms of service in relation to a continuing care or capitation arrangement.

Section 1: Patient nameH&C number

I will withdraw from the capitation/continuing care arrangement with the above patient **with immediate effect** from (date)..... due to the following:

- Failure to keep appointments
- Failure to pay HS Charges as requested
- Breakdown in Dentist/Patient Relationship
- Unreasonable patient behaviour
- Other – please enter further details below

Further details

Section 2: Patient name H&C number

The dentist wishes to terminate the continuing care or capitation arrangement with the above patient.

I can confirm that the patient / patient representative has been given the necessary notice as set out in Schedule 2, paragraph 11 of the General Dental Services Regulations (N.I.) 1993.

Dentist signature Date

Dentist name and contract number

Practice details:

Please return this form by post to:

Business Services Organisation
Withdrawal Officer
FPS Dental Department
3rd Floor
2 Franklin Street
Belfast
BT2 8DQ