AvMA Clinical Negligence Panel – Reaccreditation
Acknowledgement Slip

Name:	Firm:
Address:	
DX:	
Email:	Telephone:

Delete section as appropriate *

*** <u>Complete this section if you will be applying for AvMA reaccreditation</u>**

I confirm that <u>I will</u> be submitting an application for reaccreditation: ☐

PLEASE NOTE THAT A COMPLETED APPLICATION MUST BE RETURNED WITHIN 2 MONTHS OF RECEIPT OF THE RE-ACCREDITATION PAPERS

*** <u>Complete this section if you will not be applying for AvMA reaccreditation</u>**

I confirm that <u>I will not</u> be submitting an application for reaccreditation: ☐

I will not be applying because:

I understand that my membership of the AvMA Clinical Negligence Panel will be withdrawn on return of this notification. I am returning my AvMA panel certificate(s).

Signed:…… Date: ……

Please return this form together with the application administration fee (only payable if applying) within the next 14 days to:

Vicki Norman
AvMA Panel Administrator
AvMA
Freedman House
Christopher Wren Yard
117 High Street
Croydon CR0 1QG
DX: 144267 Croydon 24

Please make cheque payable to '<u>AvMA</u>' or, if you would prefer, pay direct into our bank account at:

Co-operative Bank plc
Sort Code 08-92-99.
Account No. 65583630
Account: Action against Medical Accidents