Doctor's name	
Address	
Postcode	
Applicant's name	
Date of birth	
Address	
Postcode	Telephone
Email address	

Dear Doctor,

I am applying for a firearm certificate/shotgun certificate/to be registered as a firearms dealer.

Firearms applications and medical fitness

The police assess firearms applications and require all applicants to provide factual information from a doctor confirming whether they have ever been diagnosed with or treated for any of the following conditions, which can have a bearing on whether a person is suitable to be granted a firearm certificate:

- Acute Stress Reaction or an acute reaction to the stress caused by a trauma, including post-traumatic stress disorder
- Suicidal thoughts or self-harm or harm to others
- Depression or anxiety
- Dementia
- Mania, bipolar disorder or a psychotic illness, or a personality disorder
- A neurological condition: for example, Multiple Sclerosis, Parkinson's or Huntington's diseases, or epilepsy
- Alcohol or drug abuse
- Any other mental or physical condition, or combination of conditions, which may affect the safe possession of firearms or shotguns.

The list above is not intended to be exhaustive. Doctors should consider any mental, physical or neuro-developmental condition which may affect the individual's safe possession of a firearm or shotgun, whether now or in the future.

Please note that the police are not seeking your opinion on my suitability to hold a firearm certificate, as the responsibility for this decision lies with the police. They require only a factual response, from a suitably qualified* GMC-registered doctor based on my medical record.

*A doctor with a full, specialist or GP (rather than provisional) GMC registration and a licence to practise.

Consent

I understand that a doctor may share sensitive personal data with the police concerning my physical and mental health to enable the police to make a decision on my application, or on my continued suitability to possess a firearm certificate/be registered as a firearms dealer, and I hereby consent to this processing of my personal data.

I understand that the police will process the medical information supplied on a public interest basis for the legitimate policing purpose of assessing the suitability of someone to be granted a firearm or shotgun certificate.

I understand that medical practitioners have requested that my consent is provided in respect of their duty of confidentiality to allow doctors to provide information to the police, who will then process the data as described above.

I understand the police may contact my doctor or medical specialist to obtain factual details of any medical history in relation to my suitability to possess a firearm or shotgun. This applies for the life of the certificate.

CONFIDENTIAL – MEDICAL (when complete)

Firearms Licensing

Medical Information Proforma

This form must not be amended after completion by the doctor.* The Firearms Act 1968 specifies that it is an offence to knowingly or recklessly make a false statement for the purpose of procuring the grant or renewal of a certificate, with a maximum penalty of six months imprisonment and/or a fine.

*A doctor with a full, specialist or GP (rather than provisional) GMC registration and a licence to practise.

Patient details

Title

Full name

Home address

Date of birth

Email address

Medical information: To be completed by doctor*

*A doctor with a full, specialist or GP (rather than provisional) GMC registration and a licence to practise.

Please check the patient's medical record for any history of the following and tick those that apply. Where any apply, please add further details overleaf which can be limited to a statement of fact and not an opinion.

Have you had access to the patient's full medical record to complete this report? Yes ☐ No ☐

Is the medical record continuous? Yes ☐ No ☐

Have you placed a 'firearm application made' flag on the patient record? Yes ☐ No ☐

Date records begin

Date of last consultation

CONFIDENTIAL – MEDICAL (when complete)

Acute Stress Reaction or an acute reaction to the stress caused by a trauma, including post-traumatic stress disorder	Yes ☐ No ☐
Suicidal thoughts or self-harm or harm to others	Yes ☐ No ☐
Depression or anxiety	Yes ☐ No ☐
Dementia	Yes ☐ No ☐
Mania, bipolar disorder or a psychotic illness	Yes ☐ No ☐
A personality disorder	Yes ☐ No ☐
A neurological condition: for example, Multiple Sclerosis, Parkinson's or Huntington's diseases, or epilepsy	Yes ☐ No ☐
Alcohol or drug abuse	Yes ☐ No ☐
Any other mental or physical condition, or combination of conditions, which may affect the safe possession of firearms or shotguns.	Yes ☐ No ☐

The list above is not intended to be exhaustive. Doctors should consider any mental, physical or neuro-developmental condition which may affect the individual's safe possession of a firearm or shotgun, whether now or in the future.

Please sign below. Please provide further information if you have ticked yes to any of the above questions

Patient name	
Date of birth	☐☐☐☐☐☐☐☐
What is the medical condition or medical conditions?	
How long has the patient been treated for this condition?	
Is the patient still being treated for this?	Yes ☐ No ☐
Details of medication prescribed	
Have there been any previous episodes of this?	

CONFIDENTIAL – MEDICAL (when complete)

CONFIDENTIAL – MEDICAL (when complete)

How is the patient now?	
Do you have any other information you believe may be relevant to the police in determining whether the patient is safe to possess firearms?	
Name of doctor	
Signature of doctor	
GMC number	
Date	
Practice stamp	

CONFIDENTIAL – MEDICAL (when complete)