IP							HSE REF NO:
J= GF	P Med	ical Partne (on or aff		p Join uary 2024)	t No	tificat	tion Form
	Part 43	3 - Section 1008A (4	4) of the	Taxes Con	solidat	ion Act 1	1997 (TCA 1997).
To be completed Please tick as relevan		dical Practitioners with other GPs whe <mark>(Please use block</mark>	o hold G	MS contra	cts witl	n the HSI	
New Partnership Ar (<i>Please Complete Sec</i>	ertnership ion A, B, C & D)						
Section A- Medical Par	rtnership [Details					
Medical Partnership Na							
Medical Partnership Ta	x Number:						
Medical Partnership Bu	isiness Ado	dress:					
Medical Partnership Eir	code						
Section B- Bank Detail							
Name and Address of E Full Name in which acc IBAN	ount is held		X X X ers GMS	X in the Med	ical Pa	rtnership	p
		Relevant Medical S Provider Individual Number:		Date from election ta			Confirmation that Percentage % Proportion of relevant medical service provider's income to be treated as income of the medical partnership (Gross Income) is 100%
Signature of Relevant Medical Services Provider: E						Date:	
Signature of Relevan	Date:						
Signature of Relevant Medical Services Provider: D							Date:
Signature of Relevan	nt Medical S	Services Provider: _					Date:

Please attach a 2nd form if there is not enough space for all of Partners in the Practice to be included in Section C and to sign.

Signature of Relevant Medical Services Provider: _____ Date: _____

Signature of Relevant Medical Services Provider: ______ Date: _____

GP Medical Partnership Joint Notification Form (on or after 1 January 2024)

Section D - List all relevant Medical Service Providers GMS who are being removed from the Partnership								
Relevant Medical Service Provider Name	GMS/ PCRS Number	Relevant Medical Services Provider Individual Tax Number:	Date from which the joint election takes effect.	Confirmation that Percentage % Proportion of relevant medical service provider's income to be treated as income of the medical partnership (Gross Income) is 100%				
Signature of Relevan	Date:							
Signature of Relevan	Date:							
Signature of Relevan	Date:							
Signature of Relevar	Date:							

Signature of Relevant Medical Services Provider:	Date:	
Signature of Relevant Medical Services Provider:	Date:	