 **SCO19 Firearms Enquiry Team**

 3rd Floor

 Marlow House

109 Station Road

Sidcup

DA15 7ES

 Email: fetlondonall@met.police.uk

 Website : [www.met.police.uk](http://www.met.police.uk)

**Application for a firearm and/or shotgun certificate or registration as a firearms dealer (RFD)**

Dear General Practioner,

The patient is required to provide a factual medical report when applying for the grant of one of the above mentioned certificates.

It is imperative you know that the factual information provided by yourselves will be used in conjunction with further vetting procedures including police indices check. The final decision remains **SOLELY** with the Firearms Licensing Manager.

This is non –contractual work and any fees attracted by this report are a matter between the patient and the practice.

We appreciate you taking the time to work with us on this matter.

Yours faithfully,

Firearms Licensing Manager

Please place a firearm code or a note on the patient’s record.  **If the patient presents or is diagnosed with any of the  relevant medical conditions (listed overleaf) or if there are any other factors that give rise to concern, please contact the police immediately so that we can review the person’s continued suitability.**

Please use the following firearm codes which can be used with the four main IT systems used in GP practices in England, Wales and Scotland.  The Read code should remain on the patient record while the firearm certificate or registration as a dealer is valid.  We will inform you if the certificate is revoked, cancelled or expires, whereupon you should inactivate the Read code.

If the patient is no longer registered with you please let us know as soon as possible.

**Firearm Read codes for the encoded reminder**

|  |  |  |  |
| --- | --- | --- | --- |
|  **Read Codes**  | For clinical systems using Read v2: EMIS, INPS Vision, MICROTEST Evolution [Note that the stops are important parts of the code and must be included]  | For clinical systems using CTV3:  TPP SystmOne  | SNOWMED CT  |
| Has firearm certificate or registration as a dealer  | 9DP..  | XaYbL  | 812101000000101  |
| No longer has firearm certificate or registration as a dealer  | 9DT..  | XaeXt  | 1033721000000109  |

*.*

**Further information**

If you need further information about any aspect of the process or your involvement, please telephone or email the firearms licensing department.

Yours sincerely

Firearms Licensing Manager

**MEDICAL FORM - CONFIDENTIAL (when complete)**

**Firearm, Shotgun and**

**Explosive Licensing Medical Information Proforma**

|  |  |
| --- | --- |
|  **GRANT (Tick Here)** |  **RENEWAL (Tick Here)**  |

|  |
| --- |
| **APPLICANT DETAILS** |
| **Title:** |  | **Full Name:** |  |

|  |
| --- |
| **Home Address:** |
| **Date of Birth (dd/mm/yy)** |  |
| **MEDICAL INFORMATION (To be completed by GP) Please check the applicants medical records for any history of the following conditions and tick those that apply. Where you have checked a box, please expand overleaf with more detail. We are no asking for your opinion, only for you to interrogate the medical notes and provide of the following. Any decision into suitability to hold a certificate belongs to the Chief Officer of Police or their designated person.** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Acute stress reaction as a result of trauma** |  | **Personality disorder** |  |
| **Depression or anxiety** |  | **Any Neurological Impairment****For example MS/Parkinson’s, Huntingdon’s, epilepsy, or any condition requiring consultation by neurological specialist.** |  |
| **Suicidal thoughts or self-harm** |  | **Alcohol and/or drug abuse/ dependency.** |  |
| **Serious Mental Illness** **For Example Mania, bipolar disorder, psychotic illness** |  | **Dementia** |  |
| **Any terminal diagnosis within the last 2 years** |  | **Additional comments GP wishes to add (Please use next page)** |  |

|  |
| --- |
| **Enduring Marker/Firearms Flag placed on patient’s record? Y\_\_\_\_ N\_\_\_\_** |
| **Name of GP (Print):** **GP Signature:****Date:** | **Practice Stamp:** |

|  |
| --- |
| **FURTHER DETAILS (Please expand here if you have identified the presence of any of the aforementioned medical conditions)** |
| **Please sign below ONLY if you have provided details on this page, otherwise sign and date on Pg1.** |
| **Name of GP (Print):****Signature of GP:****Date:** | **Practice Stamp:** |