

Application for Inclusion in the Pharmaceutical List to Provide Pharmaceutical Services – Change of Provider

(Please delete words/sections which do not apply)

TO HEALTH BOARD

1. Applicant’s details

I am/we are applying as an Individual/ a Pharmacist/ a Corporate Body. (*If applying as Corporate Body please also provide Superintendent Pharmacist details below)

I/We (name of person making application)

of (correspondence address and name of company if relevant)

apply to have my/our name(s) included in the pharmaceutical list. The application is in respect of the provision of services from premises from which the pharmaceutical services specified in Part 4 below are already provided (complete Parts 2, 3, 4 and 5 and sign and date the application at 6.

*Our Superintendent Pharmacist is

2. Premises details

(a) The premises from which I/we propose to provide pharmaceutical services are at—

(b) **if applicable the Responsible Pharmacist at the said premises will be—

Name

GPhC Registration No.

3. Date commencing

I/We undertake to provide the pharmaceutical services specified at Part 4 from the said premises from (date)

and it is proposed that the premises will be open during the following hours (taking into account the Board's Hours of Service Scheme.)

4. Services to be provided

I/We propose to continue to provide the following pharmaceutical services as may be approved by the Board in accordance with the terms of service for pharmacists.

5. Application Details

(a) The name of the person who is currently providing services from the premises named in Part 2(a) is—

(b) There will be no change in the pharmaceutical services provided and the provision of services by me/us will be continuous/interrupted.

It is preferred that services will be continuous however if the service will be interrupted please state why and for what period below.

6. I/We undertake to provide the services as detailed in this Form and undertake to provide such of these services as may be approved by the Board in accordance with the terms of service for the time being in operation.

Signed

Print Name

Date

NOTES:

(1) An application on Form A (2) will be required by any person already included or who wishes to be included in the pharmaceutical list to undertake to supply pharmaceutical services from premises from which pharmaceutical services are already provided. Any person already included or who wishes to be included in the pharmaceutical list to relocate current premises or to provide services from new premises should complete Form A (1).

(2) Please note that medicines cannot be dispensed from the premises until they are registered by the General Pharmaceutical Council. Although an application to be included in the pharmaceutical list can be considered in advance of such registration, registration details and any other information required but not given at the initial application stage must subsequently be provided on Form B before inclusion in the list is confirmed.

*(3) **Responsible Pharmacist details should be provided if full pharmaceutical services are being provided.*

(4) Payment cannot be made for NHS services provided before the date of entry in the pharmaceutical list recorded in Form C as issued by the Board.

Notification of Information Not Given on Form A1/A2

(Please delete words/sections which do not apply)

TO HEALTH BOARD

1. I/We (name of person making application) []

Of (correspondence address and name of company if relevant)

[]

to be included in the pharmaceutical list to provide pharmaceutical services from premises as specified in Form A (1) or (2).

2. The premises are now—

(i) constructed Yes [] No []

(ii) leased/conveyed to me/us and I/we took possession of them on []

(iii) registered by the General Pharmaceutical Council in my/our name with effect from []

(iv) The reference number is []

3. *If applicable, the Responsible Pharmacist at the said premises will be—

Name []

GPhC Registration No. []

4. I/We undertake to provide the services as detailed in Form A 1/A 2 and undertake to provide such of these services as may be approved by the Board in accordance with the terms of service for the time being in operation.

Signed []

Print Name []

Date []

NOTIFICATION OF DATE OF ENTRY ON PHARMACEUTICAL LIST

To [applicant(s)]

Your name(s) and premises (Insert Details)

have been included in the Board's pharmaceutical list, to provide the following pharmaceutical services

from (insert date)

Signed

Date

On behalf of Health Board

Notification of Date of Inclusion in Provisional Pharmaceutical List

To [applicant(s)]

I acknowledge receipt of Form A (1)/A(2) applying for your name to be included in the pharmaceutical list to provide the following services

from (provisional date)

Entry of your name in the pharmaceutical list cannot be confirmed until you have submitted Form B as respects the matters in relation to which you were unable to make affirmative statements in paragraphs 2(b) of Form A(1) or, as the case may be, unable to complete 2(b) of Form A(2).

The information required is

Signed

Date

On behalf of Health Board

NOTE:—

Provisional entry in the list does not entitle you to dispense medicines or appliances from the premises nor to receive payment for the provision of pharmaceutical services under the NHS.