SCHEDULE Regulation 7

"SCHEDULE 2 Regulations 5(2) and (11),8(3) and (4) and Schedule 1,paragraph 6

FORM A (1)	*Application for inclusion in the pharmaceutical list to provide pharmaceutical services – relocation or new application.*	Regulation 5(2)
FORM A (2)	*Application for inclusion in the pharmaceutical list to provide pharmaceutical services – change of provider.*	Regulation 5(2)
FORM B	*Notification of information not given on form A1/A2.*	Regulation 8(4)
FORM C	*Notification of date of entry on pharmaceutical list.*	Regulation 5(11)
FORM D	*Notification of date of inclusion in provisional pharmaceutical list.*	Regulation 8(3)
	Form of notice to be exhibited at premises from which pharmaceutical services are provided.	Schedule 1 paragraph 6

FORM A (1) **Regulation 5(2)**

Application for Inclusion in the Pharmaceutical List to Provide Pharmaceutical Services – Relocation or New Application

(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:

(a) the relocation of the premises from which I/we provide pharmaceutical services specified in Part 4. (Please complete Parts 2, 3, 4 (a) or (b) and sign and date the application at 5).

(b) the opening of new premises for the provision of pharmaceutical services specified in Part 4. (Please complete Parts 2, 4 (b) and sign and date the application at 5).

* Superintendent Pharmacist is ☐

2. Premises details

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

☐

(b) the premises from which it is proposed to provide pharmaceutical services are—

(i) already constructed Yes ☐ No ☐

(ii) already in our possession (lease or ownership) Yes ☐ No ☐

**(iii) registered by the General Pharmaceutical Council in my/our name(s)

Yes ☐ No ☐ N/A ☐

If the answer to (iii) is yes, state reference number.

If the answer to (iii) is no, give date of application for registration.

***(c) If applicable the Responsible Pharmacist at the said premises will be—

Name

GPhC Registration No.

If the application is for a relocation please proceed to Part 3, if not please proceed to Part 4(b)

3. Relocation Details

(a) To be completed only by persons whose names are included in the pharmaceutical list applying under Part 1(a)

(i) the premises in the Board's area from which I am/we are currently providing pharmaceutical services are at—

(ii) the relocation is for the following reasons:

If the relocation application is considered to be minor please complete (iii) and then proceed to Part 4(a). If relocation is other than minor please proceed to Part 4(b)

(iii) **To be completed only if the applicant considers relocation to be minor.** A minor relocation is one where there will be no significant change in the neighbourhood population served, and other circumstances are such that there will be no significant effect on the NHS pharmaceutical services provided by the applicant or any other person on the Board's list.

I/We consider the relocation fulfils the criteria for minor relocation because:—

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

If the application is for a minor relocation please proceed to Part 4(a)

If the application s for a relocation other than minor or for a new application please proceed to Part 4 (b).

4.

<u>Part 4(a)</u> – Additional information. To be completed by persons applying for a minor relocation.

Please note, the NHS Board may reject your application if they do not consider that you have provided sufficient detail.

(i) If the answer to 2(b)(ii) is no, please provide written consent from the person who may grant such possession that the premises may be used for the provision of pharmaceutical services.

(ii) Describe any adjustments you intend to make to the premises to ensure you will comply with the duties incumbent upon you, as the provider of pharmaceutical services, under section 29 of the Equalities Act 2010.

(iii) Please provide a description of the pharmaceutical services you currently and will continue to provide, along with detail of any further services you propose to provide if relocation is successful.

(iv) Please provide the date you intend to commence the provision of the services detailed above if relocation is successful.

(v) Please detail the hours in each day that you currently and will continue to provide such services, along side any intention to extend hours (taking into account the Board's Hours of Service Scheme.)

Please proceed to Part 5

<u>Part 4(b)</u> – Applicant's Assessment. To be completed by persons applying for a relocation other than minor or to open new premises.

(i) If the answer to 2 (b)(ii) is no, please provide written consent from the person who may grant such possession that the premises may be used for the provision of pharmaceutical services.

(ii) Describe any adjustments you intend to make to the premises to ensure you will comply with the duties incumbent upon you, as the provider of pharmaceutical services, under section 29 of the Equalities Act 2010.

(iii) Describe the boundaries of the neighbourhood, where you intend to provide pharmaceutical services, which your application proposes to cover.

(iv) Provide an assessment of the current provision, in the proposed neighbourhood, for which you believe there not to be adequate provision and evidence to support that view.

(v) Describe the pharmaceutical services you will provide.

(vi) State the date you intend to commence the provision of the services detailed above.

(vii) State the hours in each day that you intend to provide such services (taking into account the Board's Hours of Service Scheme.)

(viii) Provide details of the consultation conducted and a summary of views from people within the neighbourhood that the application affects.

(ix) Has there been an application to provide pharmaceutical services in the neighbourhood that encompasses the same or substantially the same area encompassed by the neighbourhood as stated at 4(ii) above within the previous 12 months?

Yes ☐ No ☐

If yes, please provide evidence of the significant change that has occurred that means in your view that it is now necessary or desirable that an application be granted in order to secure adequate provision of pharmaceutical services in the neighbourhood to which the application relates. **If the answer is no please proceed to Part 5.**

5. 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 (1) 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 additional or alternative premises. A person wishing to be included on the list to provide pharmaceutical services from premises already on the list should complete Form A (2).

(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) ***Premises need only be registered with the General Pharmaceutical Council if the intention is to dispense medicines from the premises.*

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

(5) *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.*

FORM A (2) **Regulation 5(2)**

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.

FORM B **Regulation 8(4)**

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 ☐

NOTES:

(1) Where all the information sought in Form A (1) or (2) was not provided, Form B shall be submitted with all the outstanding information.

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

(3) 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.

FORM C **Regulation 5(11)**

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

FORM D **Regulation 8(3)**

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.

Form of notice to be exhibited **Schedule 1, paragraph 6**

at premises from which pharmaceutical services are provided

National health Service, Scotland

(name of person, firm or company)

(a) Dispenser of medicines and supplier of drugs and appliances.

(b) Supplier of appliances.

Delete (a) or (b) as necessary.

These premises are open at the following times:—