**Chapter 12**

**Annex 1**

**Application Form**

**Application offering to meet an identified current need**

Application for inclusion in the pharmaceutical list for the area of

.…………………………………………… (insert name of health and well-being board).

This is an application to meet an identified current need and as such is a routine application under regulation 13 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Regulations).

Please complete this form as legibly as possible.

Applicants should note that information provided in this form may be disclosed where this application is required to be notified to other parties or in response to a request made under the Freedom of Information Act 2000. Applicants are referred to paragraph 21 of Schedule 2 of the Regulations which sets out NHS England or the relevant delegated integrated care board's responsibilities in relation to information provided in this application form which an applicant advises is confidential.

**1 Information regarding the applicant**

* 1. **Full name and correspondence address of the applicant[[1]](#footnote-1)**

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| --- |

Is this a personal address? Yes No

**1.2 Applicant’s legal entity**

**I/we am/are applying as a:**

(Please tick relevant box. Only one box may be selected. GPhC/PSNI registration numbers only need to be provided for pharmacy applications.)

**Sole trader** **My GPhC/PSNI registration number is ………………………**

**Partnership**

|  |
| --- |
| **Please list each partner and their GPhC/PSNI registration number:**  **Please continue on a separate sheet if necessary.** |

**Corporate Body**

|  |  |
| --- | --- |
| **Superintendent’s name and GPhC registration number is** |  |

**1.3 Provision of fitness information required by Part 1, Schedule 2 of the Regulations**

(Please tick relevant box)

|  |  |
| --- | --- |
| I/We have provided the required fitness information on a previous occasion to NHS England or the relevant delegated integrated care board or, before 1 April 2013, to a home primary care trust, and there is no missing information. I confirm that the previously provided information remains up-to-date and accurate. |  |
| Please set out below when and to whom the information was provided. If NHS England or the relevant delegated integrated care board cannot locate the information previously supplied after using reasonable efforts to locate it, you will be asked to provide it again. | |
| I/We have already provided the fitness information on a previous occasion to NHS England or the relevant delegated integrated care board or, before 1 April 2013, to a home primary care trust, but there is missing information. I confirm that the remainder of the previously provided information remains up-to-date and accurate. |  |
| Please indicate what information NHS England or the relevant delegated integrated care board already has and when and to whom it was provided, and confirm the missing information that is being provided. If NHS England or the relevant delegated integrated care board cannot locate the information previously supplied after using reasonable efforts to locate it, you will be asked to provide it again. | |

|  |  |
| --- | --- |
| I/We have provided the required fitness information with this application. |  |

**1.4 Relevant fee**

I/we include the relevant fee for this application.

**2 Proposed premises**

(Please tick relevant box. Only one box may be selected.)

I/we know the address of the proposed premises

I/we provide a best estimate of the location of the proposed premises

|  |
| --- |
| Please provide the address or best estimate[[2]](#footnote-2) of the proposed premises  Please continue on a separate sheet if necessary. |

(Only complete the question below if you know the address of the proposed premises)

The premises above are currently in my/our possession\* Yes No

\* by rental, leasehold or freehold

**3 Opening hours**

**3.1 Proposed core opening hours[[3]](#footnote-3)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday | Total |
|  |  |  |  |  |  |  |  |

**3.2 Total proposed opening hours[[4]](#footnote-4)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday | Total |
|  |  |  |  |  |  |  |  |

**4 Pharmaceutical services to be provided at these premises**

Essential services (paragraphs 3 to 22, Schedule 4 – pharmacies)

Or

Terms of service (paragraphs 3 to 12, Schedule 5 – DACs)

If you are undertaking to provide appliances, specify the appliances that you undertake to provide (or write ‘none’ if it is intended that the pharmacy will not provide appliances).

|  |
| --- |
|  |

Please give details of any advanced and enhanced services[[5]](#footnote-5) you intend to provide. These details should include:

* confirmation that you are accredited to provide the services where that accreditation is a prerequisite for the provision of the services;
* confirmation that the premises are accredited in respect of the provision of the services where that accreditation is a prerequisite for the provision of the services; and
* a floor plan showing the consultation area where you propose to offer the services, where relevant. Where a floor plan showing the consultation area cannot be provided please set out the reasons for this.

|  |  |  |
| --- | --- | --- |
| **Service** | **Accredited to provide (Y/N/NA)** | **Premises accredited (Y/N/NA)** |
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Please continue on a separate sheet if necessary.

I/we confirm that the pharmacy premises will have a consultation room that meets the requirements of paragraph 28A, Schedule 4 of the Regulations. Yes

**Floor plan showing consultation area**

|  |
| --- |
|  |

Please continue on a separate sheet if necessary.**5 Applications in relation to premises that are in close proximity to other listed chemist premises**

This section should only be completed if the premises included in section 2 above are adjacent to, or in close proximity to, another pharmacy or dispensing appliance contractor premises.

|  |
| --- |
| In my/our view this application should not be refused pursuant to Regulation 31 for the following reasons: |

Please continue on a separate sheet if necessary.

**6 Information in support of the application**

In making this application I/we am/are seeking to meet the current need identified on page ………[[6]](#footnote-6) of the HWB’s pharmaceutical needs assessment.

|  |
| --- |
| Please insert the identified current need you are offering to meet here. |

In the box below please explain how you intend to meet the identified current need either in whole or in part.

|  |
| --- |
|  |

Please continue on a separate sheet if necessary.

**7 Undertakings**

By virtue of submitting this application I/we undertake to notify NHS England or the relevant delegated integrated care board within 7 days of any material changes to the information provided in this application (including any fitness information provided under paragraph 3 or 4, Schedule 2) before:

* the application is withdrawn,
* while the application remains the subject of proceedings, the proceedings relating to the application reach their final outcome and any appeal through the courts has been disposed of, or
* if the application is granted, I/we commence the provision of the services to which this application relates,

whichever is the latest of these events to take place.

I/We also undertake to notify NHS England or the relevant delegated integrated care board if I/we am/are included, or apply to be included, in any other relevant list before:

* the application is withdrawn,
* while the application remains the subject of proceedings, the proceedings relating to the application reach their final outcome and any appeal through the courts has been disposed of, or
* if the application is granted, I/we commence the provision of the services to which this application relates,

whichever is the latest of these events to take place.

I/We also undertake:

* to comply with all the obligations that are to be my/our terms of service under Regulation 11 if the application is granted, and
* in particular to provide all the services and perform all the activities at the premises listed above that are required under the terms of service to be provided or performed as or in connection with essential services.

The following only applies where the applicant is seeking to provide directed services. I/We:

* undertake to provide the directed services mentioned in this application if they are commissioned within 3 years of the date of grant of this application or, if later, the listing of the premises to which this application relates,
* undertake, if the services are commissioned, to provide the services in accordance with an agreed service specification, and
* agree not to unreasonably withhold my/our agreement to the service specification for each directed service I/we are seeking to provide.

I confirm that to the best of my knowledge the information contained in my/our application is correct.

Name …………………………………………………………………………………………..

Position ………………………………………………………………………………………..

Date ………………………………...................................................................................

On behalf of the company/partnership ……………………………………………………

Contact phone number in case of queries………………………………………………….

Contact email number in case of queries ………………………………………………….

Registered office

|  |
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|  |

Please send the completed form to:

Email: [PCSE.marketentry@nhs.net](mailto:PCSE.marketentry@nhs.net)

Post: Primary Care Support England, PO Box 350, Darlington, DL1 9QN

NHS England’s [Privacy Notice](https://www.england.nhs.uk/contact-us/privacy/privacy-notice/) describes how certain services are provided on behalf of Integrated Care Boards and how personal data is used. It also explains how you can invoke your rights as a data subject. We will protect your information in line with the requirements of the Data Protection Act 2018.

1. This is the name of the legal entity applying, not the person who is completing the application. [↑](#footnote-ref-1)
2. Best estimates are to be precise as possible. Phrases such as “in the vicinity of” and “within 100m of the junction of the High Street and Church Lane” are unlikely to be considered acceptable. [↑](#footnote-ref-2)
3. Core opening hours must total 40 hours per week for pharmacies or not less than 30 hours for DACs, unless the applicant is proposing more core opening hours to meet an identified current need in which case NHS England or the relevant delegated integrated care board will need to agree with you when these additional core opening hours would be. [↑](#footnote-ref-3)
4. The total opening hours includes the core hours and any supplementary opening hours [↑](#footnote-ref-4)
5. Please note that enhanced services are those commissioned by NHS England or the relevant delegated integrated care board. Do not include services which are commissioned by the local authority/council or any other commissioner. [↑](#footnote-ref-5)
6. Insert page number. [↑](#footnote-ref-6)