**Chapter 19**

**Annex 1**

**Application Form**

**Application in respect of a change of ownership**

Application for inclusion in the pharmaceutical list for the area of

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

This is an application in respect of the change of ownership of premises and as such is an excepted application under regulation 26(1) 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**

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

|  |
| --- |
|  |

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 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]](#footnote-2). ☐

**1.5 Basis for the change of ownership[[3]](#footnote-3)**

Please can you confirm whether you are buying the pharmacy business on a:

Non debts and liabilities basis Yes  No 

Debts and liabilities basis, with or without access to the existing bank account Yes  No 

**2 Name of the current owner and address of the listed premises[[4]](#footnote-4)**

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I/we propose to carry on at the above premises, the business in the course of which the above owner is providing pharmaceutical services at the above premises.

These premises are currently in my/our possession\* Yes  No 

\* by rental, leasehold or freehold

**3 Opening hours**

**3.1 Core opening hours[[5]](#footnote-5)**

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

**3.2 Total opening hours[[6]](#footnote-6)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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 the pharmacy does not provide appliances).

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Please give details of any advanced and enhanced services[[7]](#footnote-7) 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 ☐

Or

I/we confirm that NHS England or the relevant delegated integrated care board has previously determined that the pharmacy premises is too small to have a consultation room. I/we confirm that there will be arrangements in place which enable the person performing pharmaceutical services to communicate confidentially with a person accessing pharmaceutical services:

1. by telephone or other live audio link, and
2. via a live video link. 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.

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| --- |
| 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**

6.1 Are the services you are undertaking to provide the same as those that the current owner is providing? Yes ☐ No ☐

6.2 Will there be any interruption to service provision? Yes ☐ No ☐

6.3 If the answer to question 6.1 is “no” or the answer to question 6.2 is “yes” please give full details in the box below:

Please continue on a separate sheet if necessary.

**7 Distance selling premises**

7.1 Are you applying for a change of ownership in relation to distance selling premises?

Yes ☐ No ☐

If no, continue to section 8.

If yes, please continue with this section.

7.2 Proposed premises that are on the same site or in the same building as the premises of a provider of primary medical services with a patient list.

This section should only be completed if the premises included in section 2 above are on the same site or in the same building as the premises of a provider of primary medical services with a patient list.

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| --- |
| In my/our view this application should not be refused pursuant to Regulation 25(2)(a) for the following reasons: |

Please continue on a separate sheet if necessary.

7.3 Please explain how the pharmacy procedures used within the premises will secure:

1. the uninterrupted provision of essential services during the opening hours of the premises, to persons anywhere in England who request those services, and
2. the safe and effective provision of essential services without face to face contact between any person receiving the services, whether on their own or someone else’s behalf, and the applicant or the applicant’s staff.

Please describe the procedure that will be followed where a patient attends the premises and asks for one or more of the essential services.

If you are undertaking to provide advanced services at the premises please describe how you will do so without providing any element of essential services.

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Please continue on a separate sheet if necessary.

**8 Declaration to be signed by the current owner**

I confirm that this application is being made with my full knowledge and consent, and that I will withdraw from the pharmaceutical list in respect of the premises listed in section 2 consequent upon the inclusion of the new owner in the list at that address.

Signature ………………………………………………………………………………………

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

Email …………………………………………………………………………………………

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

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

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

**9 Undertakings and declaration by applicant**

By virtue of submitting this application I/we undertake to provide pharmaceutical services at the premises listed at section 2:

* that are already listed chemist premises, and
* at which another person is providing pharmaceutical services.

I/We also 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

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. The higher fee is payable if the applicant is not already included in the relevant pharmaceutical list in respect of other premises. [↑](#footnote-ref-2)
3. This information is requested as it will inform whether, if the application is granted, the applicant will be given a new ODS code or not. [↑](#footnote-ref-3)
4. This must be the name and address as it currently appears in the relevant pharmaceutical list. [↑](#footnote-ref-4)
5. These must be the same as the current core opening hours. [↑](#footnote-ref-5)
6. The total opening hours includes the core opening hours and any supplementary opening hours. These must be the same total opening hours as at the current premises. [↑](#footnote-ref-6)
7. 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-7)