**Chapter 23**

**Annex 39**

**Relocation of Practice Premises After Outline Consent Takes Effect**

**Application Form**

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| **Name of doctor/practice** |  |
| **Correspondence address** |  |

I/we wish to change the premises from which I/we dispense.

Insert the address of the premises for which premises approval was previously given

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|   |

Please insert below the address of the premises for which you are now seeking premises approval.

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|  |

Please confirm which patient groups are accustomed to accessing the dispensing service at your current premises.

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|  |

Please use the box below to explain why you consider that the new premises are not significantly less accessible for the patient groups that are accustomed to accessing pharmaceutical services at the existing premises.

|  |
| --- |
|  |

Please continue on a separate sheet if necessary.

Please use the box below to explain why you consider that granting the application will not result in a significant change to the arrangements that are in place for the provision of pharmaceutical services (including by a person on a dispensing doctor list) or of local pharmaceutical services in any part of the HWB’s area or in a controlled locality in the area of a neighbouring HWB area where that controlled locality is within 1.6km of your proposed new premises.

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Please continue on a separate sheet if necessary.

Please use the box below to explain why you consider granting the application would not cause significant detriment to the proper planning in respect of the provision of pharmaceutical services in the HWB’s area.

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| --- |
|  |

Please continue on a separate sheet if necessary.

Please confirm if these premises are already included in the relevant dispensing doctor list in relation to a different area for which you have outline consent or historic rights. Yes  No 

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

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

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

On behalf of the practice ……………………………………………………………………

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

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

Please send the completed form to:

Email: PCSE.marketentry@nhs.net

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

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