

**APPLICATION FOR INCLUSION IN A PHARMACEUTICAL LIST  
 OR INCLUSION IN A LIST IN RESPECT OF DIFFERENT  
 SERVICES OR PREMISES**

**FOR OFFICE USE ONLY:**

Date received: ..... Date for completion: .....  
 OCS Number: .....  
 Type of application: .....

**SECTION A**

APPLICATION TO: **BRENT/HARROW\*** Primary Care Trust  
*\* delete as appropriate*

For cross-border minor relocations only:

..... Primary Care Trust\*

*\*Primary Care Trust where premises are to be located*

**APPLICANTS DETAILS:**

Name: .....

Contact Address: .....

.....

.....

Telephone No: .....

Facsimile No: .....

Email Address: .....

Website Address: .....

I/we are already included on the PCT's list\*    **Yes**                          **No**   

*\* in the same neighbourhood*



PROPOSED OPENING HOURS – please specify

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

PROPOSED CONTRACTUAL HOURS – please specify (minimum 40 hours per week unless proposing fewer)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

**SECTION E**

**PERSONS ALREADY ON PHARMACEUTICAL LIST**

NAME\* AND ADDRESS OF PHARMACY

*\* This should not be the pharmacy's trading name*

OPENING HOURS – please specify

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

CONTRACTUAL HOURS – please specify (minimum 40 hours per week unless proposing fewer)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

NAME OF SUPERINTENDENT PHARMACIST .....

**SECTION F**

**ESSENTIAL SERVICES FROM THIS PHARMACY (all essential services must be provided)**

- |                                   | Available                |
|-----------------------------------|--------------------------|
| Clinical governance and CPD       | <input type="checkbox"/> |
| Dispensing -including             |                          |
| Repeat dispensing                 |                          |
| Electronic prescribing            |                          |
| Compliance aids required under    |                          |
| The Disability Discrimination Act | <input type="checkbox"/> |
| Disposal of unwanted medicines    | <input type="checkbox"/> |
| Promotion of healthy lifestyles   | <input type="checkbox"/> |

**SECTION F Contd**

Sign-posting patients to other NHS Services   
 Support for self-care

**ADVANCED SERVICES FROM THIS PHARMACY**

	Available	Proposed	Applicant Accredited
Medicines Use Review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I enclose details of my accreditation.

I confirm that the above premises are accredited for advanced services and I have an identified dedicated consultation area where applicable.

Signature .....

I attach a copy of the floorplan where available **Yes**  **No**

**SERVICES FROM THIS PHARMACY (LOCAL ENHANCED)**

	Available	Proposed	In PhS Needs Assessment
Minor ailment schemes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palliative Care Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervised Administration Schemes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needle exchange service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescriber support services (practice based)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplementary Prescribing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient group direction service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Controlled Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Home & Intermediate Care Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Delivery Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines assessment and compliance support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head Lice Management service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gluten Free Food Supply Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulant Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language access Services/Patient Advocacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Hormonal Contraception (via PGD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out of Hours Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services to Schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Full Clinical Medication Review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disease specific medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines management for long-term conditions eg diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic eg cholesterol, HbA1c	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screening Services/Other – please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

.....  
 .....  
 .....

**SECTION F contd**



**MINOR RELOCATIONS OVER 500 METRES**

I wish to apply for this exemption for the following reasons (e.g. give account of how this move may affect communication links, patient transport links, access to services, or other social or demographic factors (e.g. there are no new roads planned which would reduce access)). Describe the nearest practicable route from the existing to the proposed premises.

Reasons for minor relocation:

Why applicant believes it is a minor relocation

The provision of services will be                    CONTINUOUS     INTERRUPTED

Period of interruption .....

Reason for interruption :

I undertake as a minimum, to continue to provide the services at the new location that are currently provided from the existing premises.

Signature: .....

**SECTION I**

**CHANGE OF OWNERSHIP**

NAME OF PREVIOUS OWNER .....

The provision of services will be            CONTINUOUS       INTERRUPTED  

Period of interruption .....

Reason for interruption .....

NAME AND ADDRESS OF PREMISES

Services being withdrawn:

I declare that I/we are withdrawing some existing premises/removing the above services.

SIGNATURE ..... DATE .....

**SECTION K**

**DECLARATION**

I/we undertake that if my/our application is granted, I/we will provide/continue to provide the pharmaceutical services specified above at the premises specified above.

I/we understand that approval for this application will be withdrawn if I/we am/are not be able to provide PhS if I/we fail, without good cause to provide those services consistently and regularly.

SIGNATURE: ..... DATE: .....

PRINT NAME: .....

ON BEHALF OF

POSITION: ..... COMPANY: .....

REGISTERED OFFICE

***Return completed form to Mrs Manu Bennion, Brent & Harrow Contractor Services,  
Harrow PCT, The Twenty One Building 21 Pinner Road, Harrow HA1 4BB***