

**APPLICATION FOR INCLUSION IN A PHARMACEUTICAL LIST  
 (EXEMPT APPLICATION)**

<b>FOR OFFICE USE ONLY:</b>	
Date received:	Date for completion: .....
	OCS Number: .....
	Type of application: .....

<b>SECTION A</b>	
APPLICATION TO:	.....Primary Care Trust
For cross-border minor relocations only:	.....Primary Care Trust*
<b>* Primary Care Trust where premises are to be located</b>	
APPLICANTS DETAILS:	
Name:	.....
Contact Address:	..... ..... .....
Telephone No:	.....
Facsimile No:	.....
Email Address:	.....
Website Address:	.....
I/we are already included on the PCT's List <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	
<i>* in the same neighbourhood</i>	

<b>SECTION B</b>	
<b>TYPE OF EXEMPT APPLICATION</b>	<b>Complete the appropriate Sections</b>
Out of town shopping centres over 15,000sq m	<input type="checkbox"/> <b>A, B, C, D, E, F, K, L</b>
Opening over 100 hours per week	<input type="checkbox"/> <b>A, B, C, D, E, G, K, L</b>
One stop primary care centres	<input type="checkbox"/> <b>A, B, C, D, E, H, K, L</b>
Wholly internet/mail order	<input type="checkbox"/> <b>A, B, D, E, I, K, L</b>
Minor relocation under 500m	<input type="checkbox"/> <b>A, B, C, D, E, J, K, L</b>
Cross-border minor relocation under 500m	<input type="checkbox"/> <b>A, B, C, D, E, J, K, L</b>



**SECTION C**

**DETAILS OF PHARMACY** (to be completed by all exemptions except for wholly internet/mail-order only)

NAME\* AND ADDRESS OF **NEW** PHARMACY

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

NAME OF SUPERINTENDENT PHARMACIST\* .....

*\* where known at the time of the application*

These premises are:

- |                               |                          |                       |                          |
|-------------------------------|--------------------------|-----------------------|--------------------------|
| Already constructed           | <input type="checkbox"/> | Under negotiation     | <input type="checkbox"/> |
| Already in my/our possession* | <input type="checkbox"/> | Registered with RPSGB | <input type="checkbox"/> |
| Not in our possession yet     | <input type="checkbox"/> |                       |                          |

*Please indicate which apply*

RPSGB Reg No: .....

Company Reg No: .....

*\* by rental, leasehold or freehold*

PROPOSED OPENING HOURS – please specify

*\*To be completed by all exemptions*

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 D**

**PERSONS ALREADY ON PHARMACEUTICAL LIST**

NAME\* AND ADDRESS OF PHARMACY

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*\* 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 E**

**ESSENTIAL SERVICES FROM THIS PHARMACY** *(all essential services are to be available)*

- Clinical governance and CPD  Available
- Dispensing –including
  - Repeat dispensing
  - Electronic prescribing
  - Compliance aids required under The Disability Discrimination Act
- Disposal of unwanted medicines
- Promotion of healthy lifestyles
- 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**

**SECTION E cont'd**

**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 management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines management for long-term condition 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"/>

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

I confirm that I am accredited for the above locally enhanced services (where relevant). I enclose details of my accreditation

Signature .....

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 **Yes**  **No**

**SECTION F**

**SHOPPING DEVELOPMENTS over 15,000 sq m gross floor space**

Name of shopping development: .....

Is this development listed on the DOH website? Yes  No

**If not**, is there

Local Authority planning permission? Yes  No

Please explain why you consider that this development should be exempt:

**SECTION G**

**Pharmacies intending to open more than 100 hours a week**

Please outline how you will staff the pharmacy during the above hours and how you will verify to the Primary Care Trust the hours you are providing NHS pharmaceutical services:

**SECTION H**

**Consortia developing one stop primary care centers**

MEMBERS OF PARTIES TO CONSORTIUM

Details of consortium agreement attached\*? Yes  No

*\*This should set out responsibilities of each member of the consortium*

*cont'd*

**SECTION H cont'd**

If not, WHEN WILL THEY BE SUPPLIED? .....

The one stop primary care centre is part of the PCT's Strategic Service Development Plan or equivalent Yes  No

Minimum medical patient list population .....

Name/s of the primary medical services provider/s of these patient lists:

The range of health, community and/or social services to be provided from the centre:

**SECTION I**

**Wholly internet/mail-order based pharmacy**

REGISTERED ADDRESS:

NAME OF SUPERINTENDENT PHARMACIST\* .....

*\* where known at the time of the application*

REGISTERED WITH Royal Pharmaceutical Society GB      **Yes**         **No**  

REG NO: .....

COMPANY REG NO: .....

Please explain how you will provide remotely all essential services under the new contractual framework:

I declare that I/we will not/will not intending to provide any NHS services to patients direct and personally from these premises.

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

**SECTION J**

**RELOCATIONS UNDER 500 METRES including cross-boundary**

I am applying for this exemption. I confirm that the relocation is under 500m     

Distance (by the most practicable route) from existing pharmacy ..... **km**

Address of current premises:

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

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 K**

**All exemptions**

I wish to apply for this exemption for the following reasons:

**SECTION L**

**All exemptions**

**DECLARATION**

I/we undertake that if my/our application for exemption is accepted, I/we will provide/continue to provide the pharmaceutical services specified above, at the premises specified above, as outlined in the exemption.

I undertake to provide services at the hours specified in Sections D. I understand that failure to do so consistently and regularly could lead to the withdrawal of the right to provide NHS services.

I/we understand that approval for this exemption application will be withdrawn if I/we am/are not able to provide Pharmaceutical Services, if I/we fail, without good cause to provide those services consistently and regularly, once the application has been granted.

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

PRINT NAME: .....

*ON BEHALF OF*

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

REGISTERED OFFICE:

***Return completed form to Mrs Manu Bennion, Harrow PCT, Twenty One Building, 21 Pinner Road, Harrow Middx HA1 4BB***