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Application for a Minor Relocation within a Health Board (HB) area, between neighbouring Health Boards or a Temporary Relocation.

Regulation15 (1) of the NHS (Pharmaceutical Services) (Wales) Regulations 2020

**Please complete this form in BLOCK CAPITALS. Please note that incomplete forms will be returned to applicants.**

**PART A (Application details)**

Type of application (please tick appropriate box)

* Minor Relocation ð Minor Relocation

(within HB area (between neighbouring

Regulation 19) HB areas Regulation 20)

* Temporary Relocation (Regulation 21)

**PLEASE INDICATE IN WHICH HEALTH BOARD AREA YOU WISH TO BE INCLUDED: (Please indicate ONE only)1** (\*Please also indicate the locality within the Health Board below, by deleting as appropriate)

* Swansea Bay University Health Board(\*Neath Port Talbot/ Swansea)
* Aneurin Bevan University Health Board (\*Blaenau Gwent/Caerphilly /Monmouthshire /Newport/Torfaen)
* Betsi Cadwaladr University Health Board(\*Anglesey/ Conwy/ Denbighshire/ Flintshire/ Gwynedd/ Wrexham)
* Cardiff and Vale University Health Board (\*Cardiff/Vale of Glamorgan)
* Cwm Taf Morgannwg University Health Board (\*Bridgend/Rhondda Cynon Taf/Merthyr Tydfil)
* Hywel Dda University Health Board(\*Carmarthenshire/ Ceredigion/ Pembrokeshire)
* Powys Teaching Health Board

###

1 The application should be made to the Health Board in whose area the premise is located.

1. **Information regarding the applicant**
	1. **Full name and contact details of the applicant**

|  |  |
| --- | --- |
| **Mr/Mrs/Ms/Dr/Other:** |  |
| **Name:** |  |
| **On behalf of:****(name of partnership/ company)** |  |
| **Correspondence Address:****(with postcode)** |  |
| **Contact Telephone:** |  |
| **E-mail Address:** |  |

* 1. **Applicant’s legal status**

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

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

* **Sole Trader ð Partnership**

(please see (a) below)

* **Body Corporate**

(please see (b) below)

**I declare that I am a registered pharmacist and my GPhC Registration**

**GPhC No:**

**Number is:**

1. **If a Partnership, please list each partner and their GPhC Registration Number.**

|  |  |
| --- | --- |
| **Name:** | **GPhC Registration Number:** |
|  |  |
|  |  |

1. **If a Body Corporate, please provide details:**

|  |  |
| --- | --- |
| **Name of Superintendent/Director:** | **GPhC Registration Number:** |
|  |  |
|  |  |
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(Please continue on a separate sheet if necessary).

* 1. Provision of Fitness information

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

* I am/We are already included in the Health Board’s Pharmaceutical List and therefore not required to provide the Fitness information in connection with this application.
* I am/We are **not** already included in the Health Board’s Pharmaceutical List and enclose the Fitness information required by Schedule 2, Part 2 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020 (AWP7 and AWP8).
* The application is being made by a Body Corporate and we have provided the required Fitness information to our Home Health Board(Please provide the name and address of your Home Health Board in the box below).
	1. Relevant fee (see attached schedule of charges form AWP6)
* I/We enclose the relevant fee for this application.

(Please note that cheques are to be made payable to Velindre University NHS Trust)

1. **Address of the current premises** (This must not be the address of a temporary relocation under Regulation 21)

|  |  |
| --- | --- |
| **Premise address:****(with postcode)** |  |

* 1. If this is a relocation across neighbouring Health Boards (Regulation 20 (1) (c)) please state the Health Board where the existing premises is located:

**2.2** Did you relocate to these premises within the last twelve months?

* Yes **ð** No

If yes please provide the date of relocation:

1. **Address of the proposed premises**

|  |  |
| --- | --- |
| **Premise address:****(with postcode)** |  |

Please provide the full address of the proposed premises from which you intend to operate, in the box below.

These premises are currently in my/our possession by rental, leasehold or freehold (please delete as appropriate):

* Yes **ð** No

These premises are already constructed

* Yes **ð** No

The sale/lease of the premise is under negotiation

* Yes  **ð** No

These premises are registered by the GPhC

* Yes **ð** No

**GPhC No:**

**3.1** What is the distance between the current and the proposed premises by the shortest route on foot in kilometres?

**3.2** Please describe the route between the current and proposed premises:-

**3.3** Are the services you are undertaking to provide the same as those that are provided at the listed premises?

* Yes **ð** No

**3.4** Are the new premises significantly less accessible to patients who are accustomed to accessing Pharmaceutical Services at the existing premises?

* Yes **ð** No

**3.5** Will there be any interruption to service provision?

* Yes **ð** No

If the answer to question 3.3 is ‘no’ or the answer to question 3.4 or 3.5 is ‘yes’ please give full details in the box below:

**3.6** If the application is for a temporary relocation please state the circumstances that necessitated this application. In such instances please provide the expected duration of the temporary relocation and distances in kilometres from the existing premises:

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

**4.1 Pharmacy Applications** Please tick to confirm that you intend to provide:-

* Essential Services (Schedule 5, paras 3 to 22)

Please provide details of any advanced and enhanced services you may wish to provide from these premises:

**NHS Services:**

**Please continue on a separate sheet if necessary.**

**4.2 Dispensing Appliance Contractors (DACs)** Please tick to confirm that you will provide proper and sufficient appliances in accordance with the:-

* Terms of Service (Schedule 6, paras 3 to 12)

Please specify the services that you undertake to provide:

**NHS Services**

**Please continue on a separate sheet if necessary.**

**5. Opening hours**

**5.1 Proposed core opening hours**

These should be the same as the current core opening hours at the premises, unless as part of this application you are offering to provide more core opening hours. Core opening hours must total 40 hours per week for pharmacies or not less than 30 hours for Dispensing Appliance Contractors (DACs).

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

**5.2 Proposed total opening hours**

The total opening hours include the core hours entered above plus any supplementary opening hours. The total opening hours should mirror the hours currently provided, unless as part of this application you are offering to provide more opening hours.

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

**5.3 Proposed hours when pharmacy will be closed**

Please indicate the hours which you propose to close, i.e. lunchtimes, etc, if applicable.

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

**PART B (Personal information)**

**(The details contained in PART B of this form will not be circulated to parties with an interest in this application)**

**SECTIONS 6-9 BELOW ARE TO BE COMPLETED BY APPLICANTS WHO ARE APPLYING TO RELOCATE TO A NEIGHBOURING HEALTH BOARD AND ARE NOT ALREADY INCLUDED IN THAT HEALTH BOARD’S PHARMACEUTICAL LIST**.

1. **Pharmaceutical Qualifications**

**6.1** Please state in which country you qualified

as a pharmacist:

**6.2** Were your qualification examinations taken in the English language?

* Yes **ð** No

**6.3** If the answer to 6.2 is No, please provide the original certificate of proficiency in the English language with your application(e.g. International English Language Testing System (IELTS) or equivalent)

**6.4** Please provide details of your pharmaceutical qualifications (continue on a separate sheet if necessary):

|  |  |  |
| --- | --- | --- |
| **Qualification** | **Institution** | **Date of****Qualification** |
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1. **Entitlement to work in the UK**

**7.1**. Are you a British Citizen or EEA National?

* Yes **ð** No

British Citizens and EEA Nationals should proceed to section 8 of this form. Other applicants should complete questions 7.2 to 7.4.

**7.2** Do you have evidence of entitlement to enter and work in the UK (e.g. settled status, spouse of British Citizen etc) or are you in the UK under the Commonwealth Working Holidaymaker’s Scheme?

* Yes **ð** No
	1. Did you enter the UK as a pharmacist, or obtain a current entry clearance to do so, before 1 April 1985?
* Yes **ð** No
	1. What is your immigration status?

|  |  |  |  |
| --- | --- | --- | --- |
| a. |  | Limited leave to remain until (date) |  |
|  |  |  |  |
| b. |  | Indefinite leave to remain |  |
|  |  |  |  |
| c. |  | Subject to work provisions |  |
|  |  |  |  |
| d. |  | Self Employed |  |
|  |  |  |  |
| e. |  | Other, please specify |   |
|  |  |  |  |

Please supply original evidence of your immigration status, i.e. Visa. If subject to work permit provisions please provide details of the application’s progress. If self-employed please enclose documents confirming self-employed status.

**8. Statement of Professional Experience**

**8.1** Please list your career history in date order commencing with your first post (including hospital appointments).

**Please provide details of your experience. Any gaps in service must be stated, giving explanations (including overseas travel and personal reasons)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Experience/Appointment** | **Date From** | **Date To** | **Reason for****Leaving** |
|  |  |  |  |
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**Please continue on a separate sheet if necessary**

**8.2** Are you currently included in any Health Board’s (or equivalent body’s) Pharmaceutical List?

* Yes **ð** No
1. If yes, please give details and contact name, telephone number and email address of the Health Board/equivalent body

**8.3** Do you have any outstanding/deferred applications for inclusion in any Health Board’s (or equivalent body’s) Pharmaceutical List?

* Yes **ð** No

**a)** If yes, please give details and contact name, telephone number and email address of the Health Board/equivalent body

**9 Referees**

Please provide names and addresses of two referees who are willing to provide references relating to two recent posts (which may include any current post) as a pharmacist which lasted at least three months without a significant break. Where this is not possible, a full explanation and alternative referees should be given below.

**Referees must not be related to you.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Name** |  |
| **Title** |  | **Title** |  |
| **Position** |  | **Position** |  |
| **Address** |  | **Address** |  |
| **Telephone**  |  | **Telephone** |  |
| **Fax** |  | **Fax** |  |
| **E-mail** |  | **E-mail** |  |
| **How long have you know this person and in what capacity?** |  | **How long have you know this person and in what capacity?** |  |
| **Comments:** |

**It is your responsibility to make sure that your referees are expecting to be contacted and are in a position to provide you with a reference.**

I confirm that I consent to the removal of my name from the Pharmaceutical List maintained by the Health Board in whose area the current listed premises are located with effect from the date on which the provision of pharmaceutical services from the new premises will commence.

Signature ..................................................................................................

Name .......................................................................................................

Position .....................................................................................................

On behalf of the company/ partnership .........................................................**TO BE COMPLETED BY ALL APPLICANTS**

**10. Undertakings/Declarations**

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

**10.1** I/We also undertake:

* to comply with all the obligations that are to be my/our Terms of Service under Regulation 12 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.
* To participate in an acceptable system of clinical governance Schedule 5, para 28 pharmacy applications or Schedule 6, para 17 DACs.

The following only applies where the applicant is seeking to provide directed services.

**10.2** I/We:

* undertake, if the services are commissioned by the Health Board, 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.

The following undertaking at 10.3 applies only where the applicant is **not** already included in the Health Board’s Pharmaceutical List.

**10.3** I/We also undertake to notify the Health Board within 7 days of any material changes to the information provided in this application (including any Fitness to Practise information provided under Schedule 2, Part 2 until:my/our name is entered on the Pharmaceutical List;

* + the period specified in regulation 23 (2) to notify the Health Board that I/we will commence the provision of the services in respect of which the application was made has expired;
* the application is withdraw; or
	+ in the case of an application for preliminary consent being granted under Regulation 18, the period during which the preliminary consent has effect under Regulation 18 (4) has expired.

 **10.4** I/We will give an undertaking to notify the Health Board if I/we are included or apply to be included in a relevant list.

**10.5** I/We declare that I /we will be lawfully conducting a retail pharmaceutical business in accordance with Section 69 of the Medicines Act 1968.

**10.6** I/We consent to the Health Board making contact with any organisation it deems necessary to verify or validate any of the information I/we have provided in this application.

**10.7** I/We declare that to the best of my/our knowledge the information contained in my/our application is correct

Signature ........................................Name .................................................

Position (Superintendent/Director/Other – please state)………………………………………..

Date ............... On behalf of the company/partnership.....................................

Registered office

**Please note you are able to access the current regulations at** [The National Health Service (Pharmaceutical Services) (Wales) Regulations 2020 (legislation.gov.uk)](https://www.legislation.gov.uk/wsi/2020/1073/regulation/12/made)

 **Please submit your completed application form with the relevant fee to: -**

Primary Care Services

3rd Floor, Matrix House

Northern Boulevard

Swansea Enterprise Park

Swansea

SA6 8BX

E mail: nwssp-primarycareservices@wales.nhs.uk