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Application by Doctors for Inclusion in or Amendment to a Dispensing Doctor List

Regulation 26 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.**

Type of application (please tick appropriate box)

* Outline consent to dispense ð Premise approval (including

additional/new premises)

* Outline consent to dispense and premise approval.

**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/Merthyr Tydfil/Rhondda Cynon Taf)
* Hywel Dda University Health Board(\*Carmarthenshire/Ceredigion/Pembrokeshire n)
* 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:**

|  |  |
| --- | --- |
| **Dr/Mr/Mrs/Ms/Other:** |  |
| **Name:** |  |
| **Practice Address:**  **(with postcode)** |  |
| **Practice W Code:** |  |
| **Contact Telephone:** |  |
| **E-mail Address:** |  |
| **Correspondence Address:**  **(if different from above)** |  |
| **My GMC Reference number is:** |  |

**2. Information in support of an application for outline consent.**

**2.1** In the box below please provide a description of the boundaries of the area within which you wish to provide Pharmaceutical Services. **Please also provide a map of the area described, with your application.**

**2.2** In the box below please provide the names and addresses of any pharmacy within the area described in 2.1.

|  |  |
| --- | --- |
| **Pharmacy Name** | **Pharmacy Address (with postcode)** |
|  |  |

**2.3** Have you had an application for outline consent refused, on the basis that it was not necessary or expedient to grant the application within the last 3 years?

* Yes **ð** No

If yes, please provide the reasons you feel there has been a substantial change of circumstances in relation to the area in which you have applied for outline consent:

1. **Information in support of the application for premises approval**

**3.1** Please provide the address of the practice premises from which you propose to provide Pharmaceutical Services and whether those practice premises are listed premises in relation to a different area:

|  |  |
| --- | --- |
| **Practice Address:**  **(with postcode)** |  |

* 1. Please provide the name and address of the nearest pharmacy and the distance (kilometres) between the practice premises, at 3.1, and that pharmacy:

|  |  |  |
| --- | --- | --- |
| **Pharmacy Name** | **Pharmacy Address (with postcode)** | **Distance**  **(kilometres)** |
|  |  |  |

**3.3** Is the application for premises approval for additional premises?

* Yes **ð** No

**3.4** Is the application to relocate to new premises?

* Yes **ð** No

If yes, please provide the distance (kilometres) from the new premises to the premises for which you currently have premise approval:

**3.5** If the application relates to a practice amalgamation that has taken place or will be taking place please provide the name of the doctors/contractors participating in the amalgamation.

**3.6** If outline consent has already been granted please provide a description of the area in which consent has been granted, and also please provide a map with your application.

**3.7** Please provide details of any other medical practice premises which have been granted premises approval or in respect of which an application has already been made but not yet determined by the Health Board:

* 1. Please state the reasons you consider the granting of the application will not prejudice the proper provision of Primary Medical Services, Dispensing Services or Pharmaceutical Services in the controlled locality in which the specified premises are situated.

**3.9** Please state the reasons why you consider it is necessary or expedient to grant the application in order to secure in the area in respect of which you have applied for outline consent, the adequate provision, by persons included in the list, of the services or some of the services specified in your application:

1. **Opening hours**

**Proposed opening hours for Pharmaceutical Services to be provided**

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

**4.1 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 |
|  |  |  |  |  |  |  |  |

1. **Undertakings**

By virtue of submitting this application I/We undertake to provide Pharmaceutical Services from the practice premises stated at 3.1 if the application is granted and outline consent and premise approval is in effect, in accordance with the Terms of Service for Doctors providing Pharmaceutical Services (Schedule 7).

I/We confirm that to the best of my knowledge the information contained in my/our application is correct.

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

Position (Director/Partner/Practice Manager/ Other-please state)……………………………….

Date ............................................................................................................

**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 to: -**

Primary Care Services, 3rd Floor, Matrix House,

Northern Boulevard, Swansea Enterprise Park, Swansea SA6 8BX

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