

Application for a Community Pharmacy Contractor Agreement

Send completed application form and supporting documents to the HSE Pharmacist for the area your pharmacy is located in. (See details on page 5).

SECTION 1 TYPE OF APPLICATION - *(tick one only)*

This pharmacy contract application is in respect of:

- (i) ☐ A new pharmacy
- (ii) ☐ Purchase of existing pharmacy
- (iii) ☐ Relocation of existing pharmacy
- (iv) ☐ Change in trading status e.g. sole trader to limited company
- (v) ☐ Change in beneficial ownership

SECTION 2 DETAILS OF APPLICANT - *complete either section 2(a) or 2(b)*

2 (a) If the Applicant is a Sole Trader (one pharmacist) or a Partnership (more than one pharmacist)

Name(s):

Address(es):

.....

PSI Reg No(s)..... Contact phone no(s)..... Contact email.....

Address to which correspondence should be sent if different from above:.....

.....

2 (b) If the Applicant is a Corporate Body

Name of Corporate Body:..... Companies Registration Office no:

Registered office of Corporate Body:

.....

Corporate Body contact person:.....

Contact Phone no:..... Contact email.....

Address to which correspondence should be sent if different from above:

.....

section 2(b) continued on next page →

→ continued from previous page: **2 (b) If the Applicant is a Corporate Body:**

Directors:

Name

Address

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

Beneficial owners – please provide details of directors and shareholders (including % shareholding) held. If the trading company is owned or part owned by a holding company please provide details for the holding company as well.

Name

Address

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

SECTION 3 PHARMACY DETAILS:

Name of pharmacy:.....

Address of pharmacy:.....

..... Eircode:(required)

Opening times:

	From	To	From	To
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

SECTION 4 PRACTICE ISSUES - complete **both** sections 4(a) and 4(b)

4(a) I confirm for the purposes of a pharmacy contract granted on foot of this application, that, at all times I will:

- have a refrigerator which is capable of being monitored and has an alarm fitted. **YES** ☐
- have written procedures in place to deal with refrigerator alarm activations **YES** ☐

4(b) Are you or any of the directors/owners/beneficial owners involved in any business relationship / arrangement with another healthcare professional entitled to prescribe?

YES ☐ **NO** ☐

(If **YES** answered to 4(b) – it will be necessary for you, the contract applicant, to clarify the arrangements within a Statutory Declaration which is issued to all applicants when the initial application documents have been reviewed.)

SECTION 5 PROPOSED SUPERVISING PHARMACIST DETAILS

- to be completed by the proposed Supervising Pharmacist

Name: PSI Reg No:

Address:

.....
In accordance with the Terms and Conditions of the contract – Clause 6(2), please give details of your three years experience in the practice of community pharmacy:

<u>Dates of Employment</u>	<u>Employer Name & Address</u>	<u>Position Held/ Duties</u>	<u>Total months of full-time employment</u>
.....			
.....			
.....			
.....			

I enclose:

- a copy of my PSI registration certificate for the current year
- details of my recent continuing professional development

and I confirm that I will be acting as Supervising Pharmacist in a full time capacity (at least 35 hours) at this pharmacy and no other pharmacy, from the start date of this contract

Signature of proposed Supervising Pharmacist

____/____/____
Date

Note – evidence of current Garda vetting for the proposed Supervising Pharmacist can also be submitted at this stage if available, and in any event will be required before the contract process can be completed

SECTION 6 PROPOSED SUPERINTENDENT PHARMACIST DETAILS <i>- to be completed by the proposed Superintendent Pharmacist</i>	
Name:	PSI Reg No:
Address:	
.....	
_____ Signature of proposed Superintendent Pharmacist	____/____/____ Date

SECTION 7 APPLICANT DECLARATION <i>- to be completed by the sole trader/ partner /director of applicant Corporate Body</i>		
I confirm that all the information provided on this form is accurate and correct.		
_____ Signature of applicant	_____ Name (Block Capitals)	____/____/____ Date

CHECKLIST:

This application cannot be processed further until the following 7 documents have been received:

- ☐ 1. Application form with all sections completed
- ☐ 2. Copy of the Registration Certificate from the PSI showing registration of the proposed Supervising Pharmacist for the current year
- ☐ 3. Details of recent Continuing Professional Development for the proposed Supervising Pharmacist
- ☐ 4. Copy of Certificate of Incorporation (If applicant is a Corporate Body)
- ☐ 5. Evidence of VAT Registration
- ☐ 6. Valid Tax Clearance Certificate
- ☐ 7. Letter of termination from previous contractor (except if application is for a new pharmacy opening)

OTHER DOCUMENTS:

Please note that before the contract application process is completed you must also supply:

- Copy of Current Certificate of Professional Indemnity Insurance
- Confirmation from the Pharmaceutical Society of Ireland (PSI) that the pharmacy is registered as a Retail Pharmacy Business (Copy of the PSI Registration Certificate for the pharmacy for the current year, or letter from the PSI confirming registration for the current year).
- Evidence of current Garda vetting for the proposed Supervising Pharmacist
- Certification from your IT provider that the pharmacy software used complies with HSE standards of transparency of claims in respect of owings

IMPORTANT INFORMATION:

The processing of a contract is based on the information provided on the application form; incorrect information provided at this stage could render a subsequent contract invalid. Should the information provided in relation to this application change in any way, a new application form must be completed.