**Application to agree core opening hours**

Please return to: england.pharmacysouthwest@nhs.net

|  |  |  |
| --- | --- | --- |
| **Name of contractor**  |  | **ODS Code:**  |
| **Full address of premises to which the application relates** |  |
| **Address for correspondence** *(if different)* |  |

This is an application to:

* [ ] permanently change core opening hours
* [ ]  make a one-off change of opening hours

*(Please tick as relevant)*

Please insert below the current **Core** opening hours for these premises.

*(Most pharmacies will have either 40 or 100 core opening hours per week)*

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

Please insert below the current **Supplementary** opening hours for these premises.

*(Supplementary opening hours are those which are additional to your core opening hours)*

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

Please insert below the proposed **Core** opening hours for these premises.

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

If this is a **permanent** change, please state in the box below the date from which you would like the change to take effect. At least 3 months’ notice must be given. If you are seeking to change the core opening hours within a shorter timescale, please set out your reasons below and NHS England will consider whether they can agree to a shorter notice period.

|  |
| --- |
|  |

If this is a **one-off** change, please enter the dates for the change below. At least 3 months’ notice must be given. If you are seeking to change the core opening hours within a shorter timescale, please set out your reasons below and the NHS Southwest Collaborative Commissioning Hub will consider whether they can agree to a shorter notice period.

|  |
| --- |
|  |

Please provide information on the changes to the needs of people in the area of the Health and Well-being Board, or other likely users of the premises, for pharmaceutical services that have led to your application. Additionally, please provide at least one month of footfall traffic and amount of prescriptions picked up on the day(s) / times for the proposed change to core opening hours *(e.g. if closing on Saturday only provide figures for Saturdays over the last month).*

|  |
| --- |
|  |

Signature……………………………………………………………………………………………………….

Name ……………………………………………………………………………………….………………….

Position …………………………………………………………………………………….………………….

Date ……............................................................................................................................................

On behalf of ……………………………………………………………………...……………………………

Contact email address in case of queries …………………………………………………………………

Contact phone number in case of queries …………………………………………………………………