**Application to agree supplementary 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 supplementary 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 **Supplementary** 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**. If the change will reduce opening hours, at least 5 Weeks’ notice** must be given. If you are seeking to change the supplementary 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.

|  |
| --- |
|  |

If this is a **one-off** change, please enter the dates for the change below. At least 5 Weeks’ notice must be given if there would be a reduction in opening hours. If you are seeking to change the supplementary 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.

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|  |

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

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

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

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

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

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

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