Annex 9

Template Termination Notice

*[This Annex is provided as a template only and appropriate advice and support should be sought prior to issuing such a notice]*

*[date]*

Dear [*name*]

Termination of [GMS/PMS/APMS] [contract/agreement]

Further to our recent communications, we consider that we are entitled to serve notice to terminate your [GMS/PMS/APMS] [contract/agreement] dated [*insert start date of contract*] (the "Contract") on the following grounds:

[*insert:*

* *grounds, e.g. provision of untrue information;*
* *contract clause number that provides the right to terminate;*
* *explanation of situation and evidence relied on that led to the decision to terminate*]

Your Contract will terminate on [*insert date here*]. During this period you should work with us to support our arrangements for dealing with the termination of the Contract.

If you do not agree with our decision to issue this Termination Notice, you should contact us within 28 days of this notice. If, after making every reasonable effort, we are unable to resolve the dispute, you may wish to refer the matter to the NHS dispute resolution procedure by sending a written request to:

NHS Litigation Authority

FHS Appeal Unit

1 Trevelyan Square

Leeds

LS1 6AE

You do, of course, retain the right to seek support from your representative or defence body or Local Medical Committee.

We enclose two copies of a declaration form in respect of receipt by you of this termination notice. I would be grateful if would duly complete both forms and return one copy to me. The remaining copy is to be retained by you.

If you have any queries or need further assistance concerning the content of this termination notice, please contact us.

Yours sincerely

[*name*]

[*title*]

Enclosure: Declaration form of receipt of termination notice

Declaration of Receipt of Termination Notice

I, *[insert name of contractor],* hereby acknowledge receipt of the termination notice terminating my [GMS/PMS/APMS] [contract/agreement].

I also understand that I have the right to:

* seek support from my Local Medical Committee; and/or
* refer the matter in writing to the dispute resolution process.

Please complete the following information:

|  |  |
| --- | --- |
| Title: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Print first name(s):  (in block capital letters) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Print surname:  (in block capital letters) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Date termination notice received: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

Practice Stamp: