**Chapter 36**

**Annex 2**

**Application to reduce the total number of core opening hours – pharmacy contractors**

|  |  |
| --- | --- |
| **Name of contractor** |  |
| **ODS code (also known as the F code)** |  |
| **Full address of premises to which the application relates** |  |

This is an application to:

* permanently reduce the total number of core opening hours
* make a one-off reduction to the total number of core opening hours

(Please tick as relevant).

Please insert below the current core opening hours for these premises.

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

Please insert below the proposed core opening hours for these premises[[1]](#footnote-1).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 this is a one-off change, please enter the dates for the change below.

|  |
| --- |
|  |

Please provide the information that demonstrates that your proposed core opening hours will:

* either maintain as necessary the existing level of service provision for people in the area of the pharmacy, or other likely users of the pharmacy premises; or
* maintain a sustainable level of adequate service provision for the people in the area of the pharmacy, in circumstances where maintaining the existing level of service provision is either unnecessary or not a realistically achievable outcome.

|  |
| --- |
|  |

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

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

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

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

(insert name of contractor)

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

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

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1. Please note that this form is not to be used by 100 hour pharmacies seeking to reduce their total core opening hours in line with paragraph 26(2A), Schedule 4. [↑](#footnote-ref-1)