**Chapter 36**

**Annex 19**

**Request for a planned temporary suspension of services**

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

Please set out the dates and times of the planned temporary suspension of pharmaceutical services. Please note that at least three months’ notice must be given of a temporary suspension under paragraph 23(1), Schedule 4 or paragraph 13(1), Schedule 5 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

|  |  |
| --- | --- |
| Date(s) of the temporary suspension | Times at which pharmaceutical services would not be provided |
|  |  |

Please set out in the box below the reasons for the temporary suspension.

|  |
| --- |
|  |

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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