Application to extend period of closure of practice list of patients

(Application must be submitted no less than eight weeks before the end of the current closure notice)

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| Practice stamp: |  |

Please complete the following:

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| What options have you considered, rejected or implemented in an attempt to relieve the difficulties encountered during the closure period or which may be encountered when the closure period expires? |
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| How long do you wish your closure notice to be extended by? (This period must be for more than 3 months and less than 12 months).  |
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| Is there any reasonable support the Commissioner would be able to offer, which would enable your list of patients to re-open at the end of the current closure period? |
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| Do you have plans to alleviate the difficulties you are experiencing during your closure that could be implemented during the proposed extension period? These plans would ensure your list of patients re-opens at the end of the extended period without such difficulties. |
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| Do you have any other information for the Commissioner regarding this application?  |
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Please note that this application does not place any obligation on the Commissioner to agree to this request

To be signed by all parties to the contract (where this is reasonably achievable):

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| Signed: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Print: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Signed: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Print: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |