*[The Commissioner must review the agreement to determine if there are any specific provisions that are relevant to this scenario]*

[*date*]

Dear [*name*]

Change from Individual to More than One Individual – [insert PMS agreement reference]

Please provide the information below to the Commissioner no less than 28 days before the requested contract variation.

|  |  |
| --- | --- |
| 1. Affix practice stamp:
 |  |
| 1. The names of the person(s) who will join the agreement:
 | [List all persons] |
| 1. The address, telephone number, fax number and email address of the person(s) who will join the agreement:
 | [Insert] |
| 1. Confirm that the proposed partner(s) satisfies the conditions imposed by regulations 4 and 5 of the NHS (Personal Medical Services Agreements) Regulations 2015:
 | [List all persons indicating whether each satisfies the conditions imposed by regulations 4 and 5] |
| 1. The proposed date from which this change is to be implemented:
 | [insert date] |
| Signed by current contractor, [insert name] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Signed by proposed new person, [insert name] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Signed by proposed new person, [insert name] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| [Add further signatures lines as necessary] |  |

Please note that providing information does not impose any obligation on the Commissioner to agree to this change.

Yours sincerely

[name]

[title]