[*date*]

Dear [*name*]

Application to Change the Practice Area

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

|  |  |
| --- | --- |
| 1. Affix practice stamp:
 |  |
| 1. Provide full details of the proposed practice area:
 | [insert information] |
| 1. Explain the reasons for the change of practice area:
 | [insert reasons] |
| 1. Provide any additional supporting evidence that may be relevant (e.g. current capacity, challenges or under utilised capacity, patient distributions, future service development plans (including knowledge of local developments such as housing):
 | [insert information] |
| Signed by [insert name] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [All persons who constitute the contractor must sign this notice. Please add further signatures lines as necessary] |  |

Please note that this application does not impose any obligation on the Commissioner to agree to this application.