PS/AS/1 PHARMACIST LISTING

NHS PHARMACEUTICAL SERVICES ADVANCED SERVICES MEDICINES USE REVIEW/PRESCRIPTION INTERVENTION SERVICES

This form is to be used by a Pharmacist to register on the central list maintained by Local Health Boards (LHBs) of those with their approved competency to provide a Medicines Use Review/Prescription Intervention Services

TO BE COMPLETED BY THE PRACTISING PHARMACIST

LHB area in which I normally provide Pharmaceutical Services in a Community Pharmacy (√ the LHB in which most of your working time is spent):

- ☐ Abertawe Bro Morgannwg University Health Board
- ☐ Aneurin Bevan Health Board
- ☐ Betsi Cadwaladr University Health Board
- ☐ Cardiff and Vale University Health Board
- ☐ Cwm Taf Health Board
- ☐ Hywel Dda Health Board
- ☐ Powys Teaching Health Board

Title: Mr/Mrs/Miss/Ms/other** Name: _____

Address for Correspondence: _____

_____ Postcode: _____

Telephone Number: _____ Email: _____

Date of Registration with GPhC: ____/____/_____ GPhC Number: _____

I enclose a copy of my MUR certificate* (tick if enclosed)	

* 'MUR certificate' means a certificate awarded or endorsed by a higher education institute being evidence that a pharmacist has satisfactorily completed an assessment relating to the competency framework for pharmacists providing Advanced services approved by the National Assembly for Wales. The document 'Competency Framework for the Assessment of Pharmacists Providing the Medicines Use Review (MUR) and Prescription Intervention Service' dated 23rd December 2004 is published by the Department of Health on its website www.dh.gov.uk/mpi.

AGREEMENTS AND DECLARATIONS

I agree:

I undertake to provide the Advanced Service (Medicines Use Review/Prescription Intervention Services) at pharmacy premises, complying with any relevant Directions and/or Terms of Service and to the specification in the supporting documentation to the new pharmaceutical contract.

To submit reports and records as and when required.

To, if appropriate, give notification immediately to my employer of any significant adverse incident that arises due to or related to the provision of Medicines Use Review/Prescription Intervention Services.

I declare to the best of my belief the information on this form is correct.

Signature _____ Date _____

Name (in block capitals) _____

Please submit this form as directed by LHB

OFFICE USE ONLY

Application checked by _____ Date ____/____/____
Inclusion in List approved Yes / No** Date ____/____/____

If not approved reason for non approval: _____

_____

**delete as applicable