**Annex 5.1 Section A – Mandatory Services: Application for a Contract to Provide Ophthalmic Services as an Individual or Partnership**

**1. Practice details**

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| **Practice details** | |
| Practice name: |  |
| Practice trading name (if different): |  |
| Practice address: |  |
| Please confirm that the practice premises will be available for the provision of the services from the proposed GOS contract start  date.  Please delete answer as appropriate | Yes / No |
| Practice telephone number: |  |
| Practice email address: |  |
| VAT registration number: |  |
| GOC number if applicable: |  |
| Remember to tell us if your address changes | |

**2. General Information**

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| --- | --- | --- |
| **Area** | | |
| Please indicate in which area you wish to provide mandatory services |  | |
| **Performers list** | | Please delete answer as appropriate |
| Is the applicant included in NHS England performers list?  If yes, please provide details on a separate sheet. | Yes / No | |
| **GOS Regs** | | |
| Please confirm whether any part of paragraph 5 of Schedule 3 of the General Ophthalmic Services Regulations 2008 apply to the applicant and if relevant provide details on a separate sheet. |  | |
| **Other GOS contracts** | | Please delete answer as appropriate | Please delete answer as appropriate |
| Do you have other contracts to provide ophthalmic services?  If yes, please provide details on a separate sheet | Yes / No | |
| **Health body status** | | Please delete answer as appropriate |
| Do you wish to be considered as a health body for the purposes of this contract? | Yes / No | |

**3. Owner(s)/partner(s)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Full name Position General or Limited Partner** | | | **Please tick which apply** | | | **GOC**  **reg no** |
| **Reg'd Reg'd Reg'd optom OMP DO** | | |
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| **Full name Position Lay person** | | |
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**4. Professional staff (employed either directly or indirectly)**

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| **Performer(s)** | | | |
| **Full name DOB Qualifications GOC reg no** | | | |
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| **Dispensing optician(s)** | | | |
| **Full name DOB Qualifications GOC reg no** | | | |
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**5. Hours**

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| **Hours services provided** | |
| Please note these hours are the times you provide GOS (i.e. when you will have an optometrist or ophthalmic medical practitioner available to test sight under GOS) which may be different from the practice opening times | |
| Monday |  |
| Tuesday |  |
| Wednesday |  |
| Thursday |  |
| Friday |  |
| Saturday |  |
| Sunday |  |

**6. Premises, equipment and record-keeping**

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| **Premises** | | |
| Size of premises – in particular the rooms that will be available for sight testing | |  |
| Waiting areas available – in particular the seating arrangements that are available | |  |
| Please supply any other relevant information relating to premises to support your application (continue on a separate sheet if necessary): | |  |
| **Equipment** | | |
| Please list relevant equipment in support of your application (continue on a separate sheet if necessary): | |  |
| **Record-keeping** | Please delete answer(s) as appropriate | |
| How will individual records be maintained? | | Manual / Computerised / Combination |
| Please specify where the records will be kept and confirm this will be a secure location and by whom | |  |
| Please supply any other relevant information relating to record-keeping and information governance arrangements to support your application (continue on a separate sheet if  required): | |  |
| Please provide the name  and position of the person(s)  responsible for procedures relating to data protection (including confidentiality) and information governance: | |  |

**7. Required documentation**

|  |  |
| --- | --- |
| **Please enclose the original documentation below with your Enclosed application ? (tick - ✓)** | |
| Section B – Signed declaration to support application for a contract to provide ophthalmic services from the individual or each partner |  |
| Evidence of insurance (or where appropriate indemnity arrangements) against liability arising from negligent performance of clinical services under the contract |  |
| Evidence of public liability insurance relating to liabilities to third parties arising under or in connection with the contract that are not covered by the insurance referred to above |  |
| Bank credit authority form |  |
| Any other information the Commissioner may require (please use a separate sheet where needed) |  |

**8. Undertaking and declarations**

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| **Undertaking** |
| I undertake to:   comply with the General Ophthalmic Service Contracts Regulations 2008 (as amended);   notify the Commissioner within seven days of any material changes to the information provided in the application until the application is finally determined;   provide general ophthalmic services; and   inform the Commissioner whenever changing any of the addresses named in the application for a contract to provide ophthalmic services. |

**Undertaking**

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| **Declarations** | |
| I declare that the information provided in this application is accurate in respect of:  (name of practice) | |
| I declare that I have obtained satisfactory clinical references relating to the performers named in this application. | |
| I understand that if I provide information that is inaccurate or untrue I may be prosecuted, and I declare that the information that I have provided is true and accurate to my best knowledge and belief. | |
| **Signed** |  |
| **Date** |  |
| **Name**  **(BLOCK LETTERS)** |  |
| **Position held**  **(BLOCK LETTERS)** |  |

**Please return the application and supporting documentation to:**

**NHS Business Services Authority**

**Provider Assurance – Ophthalmic**

[**nhsbsa.pao-contractadmin@nhs.net**](mailto:nhsbsa.pao-contractadmin@nhs.net)

**Tel: 0300 330 9403**