**Annex 5.2 Section A – Additional 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): |  |
| Address for correspondence: |  |
| Please confirm that you will be ready to provide services from the proposed GOS contract start date.  Please delete answer as appropriate | Yes / No |
| Contact telephone number: |  |
| Contact email address (if any): |  |
| 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 additional 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 | |
|  |  | |
| **Other GOS contracts** | | 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 – Not Applicable**

**6. Equipment and record-keeping**

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| **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 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 – 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. |
| **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