**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: | 20/20 Vision |
| Practice trading name (if different): | 20/20 Vision |
| Practice address: | 20/20 Vision  1-4 Spectacle Street  Heaton  Newcastle upon Tyne  GL45 5ES |
| Please confirm that the practice premises will be available for the provision of the services from the proposed GOS contract start  date. | Yes |
| Practice telephone number: | 0191 1234567 |
| Practice email address: | 2020vision@nhs.net |
| VAT registration number: | GB1234567 |
| GOC number if applicable: | 01-12345 |
| 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 | Cumbria, Northumberland, Tyne and Wear Area Team |
| **Performers list** | |
| Is the applicant included in NHS England performers list?  If yes, please provide details on a separate sheet. | Yes |
| **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. | N/A |
| **Other GOS contracts** | |
| Do you have other contracts to provide ophthalmic services?  If yes, please provide details on a separate sheet | No |
| **Health body status** | |
| Do you wish to be considered as a health body for the purposes of this contract? | Yes |

**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** | | |
| John Smith | Owner | General | ü |  |  | 01-12345 |
| June Smith | Partner | General |  |  | ü | D-54321 |
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| **Full name Position Lay person** | | |
| Simon Smith | Partner |  |
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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** | | | |
| David Glass | 01/01/1980 | BSc(Hons)MCOptom | 01-12346 |
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| **Dispensing optician(s)** | | | |
| **Full name DOB Qualifications GOC reg no** | | | |
| June Smith | 18/03/1970 | FBDO | D-54321 |
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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 | 9:00am – 12:30pm, 13:00pm-17:00pm |
| Tuesday | 9:00am – 12:30pm, 13:00pm-17:00pm |
| Wednesday | 9:00am – 12:30pm, 13:00pm-17:00pm |
| Thursday | 9:00am – 12:30pm, 13:00pm-17:00pm |
| Friday | 9:00am – 12:30pm, 13:00pm-17:00pm |
| Saturday | 9:00am – 12:30pm, 13:00pm-17:00pm |
| Sunday | Closed |

**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 | Total premise size 40m2, Test room x2 4m2 |
| Waiting areas available – in particular the seating arrangements that are available | Waiting area 20m2, adequate seating for 10 patients |
| Please supply any other relevant information relating to premises to support your application (continue on a separate sheet if necessary): | Staff facilities – Tea room 5m2, Wash room facilities 2m2 |
| **Equipment** | |
| Please list relevant equipment in support of your application (continue on a separate sheet if necessary): | Focimeter, Frame Ruler, Visual Field Test,  Tonometer , Distance Test chart for adults,  A distance test chart for children / non-English / learning disability, Trial lenses and accessories, Trial frame, Retinoscope, Ophthalmoscope, Distance binocular vision test, Near Binocular vision test, Slit lamp, Indirect ophthalmoscope or Volk lens  Near reading chart, Amsler Grid, Colour vision test  Stereopsis test |
| **Record-keeping** | |
| How will individual records be maintained? | Computerised |
| Please specify where the records will be kept and confirm this will be a secure location and by whom | Stored in a secure database, backed up onto a secure hard drive on a daily basis at the close of business, password protected to employees only. |
| 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): | Staff will be fully trained in GDPR compliances, training will be provided on a regular basis to ensure changes to regulations enforced. |
| Please provide the name  and position of the person(s)  responsible for procedures relating to data protection (including confidentiality) and information governance: | John Smith |

**7. Required documentation**

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| **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 | ü |
| Evidence of insurance (or where appropriate indemnity arrangements) against liability arising from negligent performance of clinical services under the contract | ü |
| 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 | ü |
| Bank credit authority form | ü |
| 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:  20/20 Vision | |
| 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** | **(Wet signature)** |
| **Date** | 18/06/2021 |
| **Name**  **(BLOCK LETTERS)** | JOHN SMITH |
| **Position held**  **(BLOCK LETTERS)** | OWNER/OPTOMETRIST |

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

**NHS Business Services Authority**

**Provider Assurance – Ophthalmic**

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