Discharge Medicine Review Service
Service Provider Listing Form

Application form which is to be submitted to NWSSP by an individual requesting approval to provide the above directed additional clinical service

Name of provider	
GPhC number	
Address	
Postcode	
Contact telephone number	
e-mail address (for NHS SSP use only)	
Date of application	

Certifications, Agreements and Declarations (please tick to confirm)

Registered pharmacy technician

☐ I have completed the Generic Skills modules on the National Clinical Services Accreditation portal (NCSA); (including the choose pharmacy application form)

☐ I am a registered pharmacy technician meeting the requirements of the General Pharmaceutical Council;

☐ I have successfully completed the HEIW medicines reconciliation e-learning knowledge base module;

☐ I agree to NWSSP undertaking an enhanced Disclosure and Barring Service (DBS) check or have already completed a Disclosure and Barring Service (DBS) check with NWSSP;

☐ I agree to the details included in this form being included in a list of individuals approved to provide the service and that the NWSSP may disclose my accreditation status to pharmacy contractors by whom I am employed;

☐ I agree to provide the service in accordance with the service specification; and

☐ I shall notify the Medical Director of the relevant LHB of any significant adverse incident which arises due to or related to provision of this service.

OR

Pharmacist

☐ I am a pharmacist who is already accredited to provide the existing DMR service and have access to choose pharmacy platform;

☐ I have completed the Generic Skills modules on the National Clinical Services Accreditation (NCSA) portal; (including the choose pharmacy application form)

☐ I agree to the details included in this form being included in a list of individuals approved to provide the service and that the NWSSP may disclose my accreditation status to pharmacy contractors by whom I am employed;

☐ I agree to provide the service in accordance with the service specification; and

☐ I shall notify the Medical Director of the relevant LHB of any significant adverse incident which arises due to or related to provision of this service.

Declaration

I declare that the information on this form and any evidence provided is correct and I seek acceptance as a provider of this directed additional clinical service.

Applicant Signature:	Date:
Name (Printed)	

Please submit this form to NWSSP at: nwssp-primarycareservices@wales.nhs.uk