

FREE CONTRACEPTION SERVICE:

COMMUNITY PHARMACY CONTRACTOR EXPRESSION OF INTEREST FORM

I..... on behalf of.....hereinafter called the "Community Pharmacy Contractor") having a Community Pharmacy business as set out below hereby agree to provide the free Community Pharmacy counselling/advice and dispensing Service to Relevant Women as defined in and in accordance with Section 67E of the Health Act, 1970 and within the context of the Community Pharmacy Contract held with the HSE.

1.	Supervising Pharmacist's Full Name <i>(as it appears on the Pharmaceutical Society of Ireland (PSI) Register)</i>									
2.	GMS Contract number of Community Pharmacy	<table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>								
3.	PSI Number of Community Pharmacy	<table border="1" style="display: inline-table; width: 300px; height: 20px;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>								
4.	PSI Number of Supervising Pharmacist	<table border="1" style="display: inline-table; width: 150px; height: 20px;"><tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr></table>								
5.	Community Pharmacy Address									
6.	Community Pharmacy Eircode									
7.	Correspondence Address									
9.	Telephone Number									
10.	Email Address									

By signing below, the Parties hereby agree to the above.

<p>Signed by the Supervising Pharmacist on behalf of the Community Pharmacy Contractor:</p> <p>_____</p> <p>Printed Name:</p> <p>_____</p> <p>Date:</p> <p>_____</p>	<p>Signed by an Authorised Representative of the HSE:</p> <p>_____</p> <p>Printed Name & Title:</p> <p>_____</p> <p>Date:</p> <p>_____</p>
---	---

The HSE intends to compile a list of names and contact details of Community Pharmacy Contractors who are providing this Service for patient information and service accessibility purposes.

If you would like for the Community Pharmacy, the subject of this expression of interest, to be included on this list please tick the box