SIDE 1 **FORM P/ESP/1 (Rev 4/22)**

COMPLETE AND RETURN THIS APPLICATION FORM TO THE DEPARTMENT OF HEALTH VIA: PHARMACY DEPARTMENT, BSO, 2 FRANKLIN STREET, BELFAST, BT2 8DQ

ESSENTIAL SMALL PHARMACIES SCHEME

I/We apply for a payment under the above Scheme in respect of the pharmacy named at 1 below, which is currently included in the Pharmaceutical List.

1 Contractor Number and Name of Pharmacy (BLOCK CAPITALS) ______________________

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2 Address of Pharmacy (BLOCK CAPITALS) ______________________

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3 Contractor Number, Name and Address of Nearest Other Pharmacy (BLOCK CAPITALS) ______________________

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4 The distance between my/our pharmacy and that named in 3 above is -

[ ] Kilometres

5 The normal number of hours of service provided each week by the pharmacy named at 1 above is

[ ] Hours

SIDE 2

6 The number of prescriptions dispensed at the pharmacy named in 1 above during the previous 12 calendar months:

[ ] Prescriptions

Signed ______________________________ Date ________________________
(Contractor)