OPHTHALMIC CONTRACTOR NOTIFICATION OF CHANGES TO OPHTHALMIC LISTING AND SERVICE PROVISION INFORMATION

Practice Name: _____

GOS Practice Code: _____

Address: _____

Postcode: _____

Telephone No: _____

Practice/Contractor Email Address:

_____

Existing Contractor Registration (ie Corporate Body, Optometrist Owned or Ophthalmic Medical Practitioner owned):

_____

Ophthalmic List Information

1. Changes to Contractor Registration

New Name and/or Address of practice (including telephone number and email):	**New Contractor Registration** (ie **Corporate Body, Optometrist Owned or Ophthalmic Medical Practitioner owned**)

This completed form should be returned to Ophthalmic Services, Business Service Organisation, 2 Franklin Street, Belfast BT2 8DQ or, scanned and emailed to: Karen.Lee@hscni.net

2. Changes to Opening Days/Hours on which GOS and Enhanced Services are provided:

New Opening Days	New Opening Hours

3. Names of staff assisting in provision of GOS:

(a) Existing Staff

Name	GOS Personal Code	GOC/GMC Number	Employed or Locum

(b) New Staff

Please annotate clearly if you wish the new staff below to have access to CCG user account for eReferral.

Name	GOS Personal Code	GOC/GMC Number	Employed or Locum	CCG user account requested Y/N

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Note: If an NIECR account is required for an optometrist please complete the separate NIECR application form available in the Ophthalmic eForms tab on the Ophthalmic Portal home screen.

(c)Leavers

Please note that any existing CCG user accounts for your practice for the optometrists listed below will be DELETED

Name	GOS Personal Code	GOC/GMC Number	Employed or Locum

4. Request for provision of General Ophthalmic Services - Mobile Eye Services:

Request to provide Mobile Eye Services Yes ☐

5. Request to recommence/resume General Ophthalmic Services by a Contractor who had temporarily withdrawn:

Request to resume General Ophthalmic Service provision at the practice

YES ☐

6. Withdrawal of General Ophthalmic Services:

(Please state which Service is to be withdrawn)

General Ophthalmic Services (including mobile eye services) ☐

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Health and Social Care

Business Services Organisation

Mobile Eye Services only ☐

Reason for withdrawal:

_____

_____

_____

Other (e.g. Suspension by Tribunal)

_____

_____

7. Enhanced Service Provision:

Please state the detail of the notification of change in Enhanced Service Provision. Please state if this is a new request for registration for provision or withdrawal of provision by your practice.

Name of Service *(please state correct and full name of enhanced service)*	Request to Provide	Request to Withdraw

8. Names of optometrists accredited for enhanced service (s) provision:

Please state clearly in the last column which enhanced service the optometrist is accredited to provide.

Please note:

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Health and Social Care

Business Services Organisation

i) **It is the responsibility of the GOS contractor to validate and ensure that the optometrist (s) is accredited for Strategic Planning and Performance Group (SPPG) commissioned enhanced services in Northern Ireland**

ii) **Accreditation means that the optometrist both holds the required qualification and has been enrolled with the SPPG to provide the particular enhanced service.**

(a) New Staff accredited for and who wish to provide enhanced service (s)

Name	GOS Personal Code	GOC/GMC Number	Employed or Locum	Name of Enhanced Service

(b) Staff no longer accredited for enhanced service provision or, who no longer wish to provide enhanced service (s), including staff who are leaving:

Name	GOS Personal Code	GOC/GMC Number	Employed or Locum	Name of Enhanced Service

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I provide notification of the above changes to aforenamed practice ophthalmic listing and service provision:

Signed: _____

Print Name of GOS Provider/Contractor: _____

Date: _____

Date the above changes are effective from: _____

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