

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

**Current Practice Name:** \_\_\_\_\_

**Current GOS Practice Code:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_

**Current Telephone No:** \_\_\_\_\_

**Current E-Mail Address:** \_\_\_\_\_

**Existing Professional Registration** (ie Corporate Body, Optometrist  
Owned or Ophthalmic Medical Practitioner owned): \_\_\_\_\_

\_\_\_\_\_

**Ophthalmic List Information**

**1. Changes to Professional Registration /Name and/or address of  
GOS practice**

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

**2. Changes to Opening Days:**

Existing Opening Days	New Opening Days

**3. Changes to Opening Hours:**

Existing Opening Hours	New Opening Hours

**4. Names of staff assisting in provision of GOS:**

**(a) Existing Staff**

Name	GOS Personal Code	GOC/GMC Number	Employed or Locum

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](mailto:Karen.Lee@hscni.net)

**(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

**(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

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

Request to provide Mobile Eye Services      Yes

**6. Withdrawal of General Ophthalmic Services:**

(Please state which Service is to be withdrawn)

General Ophthalmic Services (including mobile eye services)

Mobile Eye Services only

Reason for withdrawal:

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Other (e.g. Suspension by Tribunal)

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**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 <i>(please state correct and full name of enhanced service)</i>	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:**

- i) It is the responsibility of the GOS contractor to validate and ensure that the optometrist (s) is accredited for HSCB commissioned enhanced services in Northern Ireland**
- ii) Accreditation means that the optometrist both holds the required qualification and has been enrolled with the HSCB 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

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

**Signed:** \_\_\_\_\_

**Print Name of GOS Provider/Contractor:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Date the above changes are effective from:** \_\_\_\_\_