

# New Medicine Service - Pharmacy Contractor Declaration Form

A completed copy of this form should be emailed by the pharmacy contractor to their [local NHS contract management team](#) prior to provision of the New Medicine Service (NMS). The local NHS contract management team does not need to acknowledge receipt of the form prior to the pharmacy commencing provision of the service.

Pharmacy details	
Name of local NHS contract management team:	
Name of pharmacy contractor:	
ODS code:	
Pharmacy address:	
Address for correspondence (if different from above):	
Eligibility to provide the service	
I / we confirm that the pharmacy is complying with the Terms of Service relating to the provision of Essential Services, and has an acceptable system of clinical governance.	
I / we confirm that the pharmacy premises contain a consultation area which meets the following requirements: <ul style="list-style-type: none"><li>i. The consultation area is a designated area where both the patient and pharmacist can sit down together</li><li>ii. The patient and pharmacist are able to talk at normal speaking volumes without being overheard by other visitors to the pharmacy, or by pharmacy staff undertaking their normal duties</li><li>iii. The consultation area is clearly designated as an area for confidential consultations, distinct from the general public areas of the pharmacy</li></ul>	
I / we confirm that the service will be provided by pharmacists that have signed the <i>NMS self-assessment of readiness for community pharmacists</i> .	
I / we confirm that a Standard Operating Procedure (SOP) is in place for the service.	
I / we confirm that all dispensing staff understand the aims and objectives of the service, are aware of the eligible conditions / therapies, understand the SOP, and understand their role, if any, in delivering the service.	
I / we confirm that my / our representatives have been in communication with local GP practices about the service.	
Pharmacy contractor's declaration	
I / we undertake to provide the New Medicine Service from the above premises from (date).	
Signed:	Date:
Contact name for queries relating to this form:	Telephone number: