

**COMPLETE AND RETURN THIS APPLICATION FORM TO THE APPROPRIATE
HEALTH AND SOCIAL SERVICES BOARD**

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 Name of Pharmacy
(BLOCK CAPITALS) _____

2 Address of Pharmacy
(BLOCK CAPITALS) _____

3 Name and Address of Nearest
Other Pharmacy
(BLOCK CAPITALS) _____

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 _____
(Contractor)

Date _____

