NHS SERVICE TYPE (TICK ONE BOX ONLY):			
GP SURGERY (NO MEDICINES ARE DISPENSED)	☐	DISPENSING PRACTICE (MEDICINES ARE DISPENSED)	☐
HOSPITAL WARD	☐	HOSPITAL PHARMACY	☐
PHARMACY	☐	PATIENT'S HOME (MEDICAL DEVICES ONLY)	☐
NHS SUPPLY CHAIN DISTRIBUTION SITE	☐	OTHER INTEGRATED CARE BOARD (ICB) SITE	☐

ORGANISATION DETAILS (ALL FIELDS ARE MANDATORY):	
NAME OF ORGANISATION:	
ORGANISATION WEBSITE ADDRESS:	

KEY MEMBERS OF STAFF (MARK NON-APPLICABLE FIELDS AS "N/A"):	
FULL NAME OF PHARMACIST / REGISTERED PRESCRIBER:	
GPHC / PSNI REFERENCE NUMBER OF PHARMACIST / REGISTERED PRESCRIBER:	
PHARMACIST / REGISTERED PRESCRIBER EMAIL ADDRESS:	
PHARMACIST / REGISTERED PRESCRIBER TELEPHONE NUMBER:	
FULL NAME OF REGISTERED PHYSICIAN:	
GMC REFERENCE NUMBER OF REGISTERED PHYSICIAN (7 DIGITS LONG):	
REGISTERED PHYSICIAN EMAIL ADDRESS:	
REGISTERED PHYSICIAN TELEPHONE NUMBER:	
FULL NAME OF PATIENT:	

PREMISES DETAILS (ALL FIELDS ARE MANDATORY):			
PRACTICE CODE (IF APPLICABLE):			
DELIVERY ADDRESS:		FINANCE / INVOICE ADDRESS:	
DELIVERY NAME / ORGANISATION:		INVOICE NAME / ORGANISATION:	
STREET:		STREET:	
TOWN:		TOWN:	
COUNTY:		COUNTY:	
POSTCODE:		POSTCODE:	

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CONTACT FOR PRODUCT RECALLS (ALL FIELDS ARE MANDATORY):	
FULL NAME:	
POSITION:	
EMAIL ADDRESS:	
TELEPHONE NUMBER:	
CONTACT FOR DELIVERY QUERIES (ALL FIELDS ARE MANDATORY):	
FULL NAME:	
POSITION:	
EMAIL ADDRESS:	
TELEPHONE NUMBER:	
CONTACT FOR FINANCE QUERIES (ALL FIELDS ARE MANDATORY):	
FULL NAME:	
POSITION:	
EMAIL ADDRESS:	
TELEPHONE NUMBER:	

OTHER CONTACT DETAILS:			
FULL NAME:	**POSITION:**	**EMAIL:**	**PHONE NUMBER:**

FORM COMPLETED BY:			
FULL NAME:	**POSITION:**	**SIGNATURE:**	**DATE:**

CLARITY QA USE ONLY:

FORM REVIEWED AND APPROVED BY (CLARITY QA USE ONLY):			
FULL NAME:	**POSITION:**	**SIGNATURE:**	**DATE:**

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