



I / we confirm that the pharmacy has an acceptable system of clinical governance and will comply with any relevant Terms of Service relating to the provision of Advanced Services and with the specifications in the supporting documentation to the new Pharmaceutical Contract.

I / we further confirm that if the LHB notifies me / us of the categories of patient who would benefit from the MUR service, I / we shall have regard to that information when determining to whom the MUR service will be offered.

I/we agree:

- To arrange for only accredited pharmacists to provide Medicines Use Review and/or Prescription Intervention Review Service(s);
- That an audit trail will be available at the Pharmacy for inspection by the LHB's authorised officers or officers acting on its behalf by BSC Wales and auditors appointed by the LHB and Audit Commission.
- To advise the LHB's Medical Director within 24 hours of any significant adverse incident which arises due to or related to the provision of Medicines Use Review and/or Prescription Intervention Review Service(s).

I/we declare to the best of my/our belief the information on this form is correct and request the premises named herein to be included in the List of premises which may provide Medicines Use Review and if appropriate Prescription Intervention Review Service(s).

Authorised Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
(On behalf of the Pharmacy)

Name \_\_\_\_\_

**Please submit this form as directed by LHB**

**OFFICE USE ONLY**

Application checked by \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Premises inspected on: \_\_\_\_\_

Premises accepted: Yes / No\*

If no, details of improvements required: \_\_\_\_\_

\_\_\_\_\_

Application approved Yes / No\* Date \_\_\_/\_\_\_/\_\_\_

If not approved reason for non approval: \_\_\_\_\_

\_\_\_\_\_

\*delete as applicable

BSC Wales

Version  
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