NHS PHARMACEUTICAL SERVICES ADVANCED SERVICES
MEDICINES USE REVIEW

This form is to be used by a Pharmacist to register on the central list maintained by Local Health Boards (LHBs) of those with their approved competency to provide a Medicines Use Review/Prescription Intervention Review Service(s)

TO BE COMPLETED BY THE REGISTERED PHARMCIST

LHB area in which I normally provide Pharmaceutical Services
in a Community Pharmacy: _____
(enter the LHB in which most of your working time is spent)

Name of registered Pharmacist: _____

Address for Correspondence:_____

_____ Postcode:_____

Telephone Number: _____

Date of Registration with RPSGB: ___/____/_____ RPSGB Registration Number: _____

	Tick
I enclose a copy of my MUR certificate*	

* 'MUR certificate' means a certificate awarded or endorsed by a higher education institute being evidence that a pharmacist has satisfactorily completed an assessment relating to the competency framework for pharmacists providing Advanced services approved by the National Assembly for Wales. The document 'Competency Framework for the Assessment of Pharmacists Providing the Medicines Use Review (MUR) and Prescription Intervention Service' dated 23rd December 2004 is published by the Department of Health on its website www.dh.gov.uk/mpi.

AGREEMENTS AND DECLARATIONS

I agree:

I undertake to provide the Advanced Service (Medicines Use Review/Prescription Intervention Service) from ……*(insert date)* at pharmacy premises, complying with any relevant Terms of Service and to the specification in the supporting documentation to the new pharmaceutical contract.

To submit reports and records as and when required.

To, if appropriate, give notification immediately to my employer of any significant adverse incident that arises due to or related to the provision of Medicines Use Review/Prescription Intervention Review Services(s).

I declare to the best of my belief the information on this form is correct.

Signature _____ Date ___/____/_____

Name (in block capitals)_____

Please submit this form as directed by LHB

OFFICE USE ONLY

Application checked by _____ Date ___/____/____

Application approved Yes / No** Date ___/____/_____

If not approved reason for non approval: _____

_____

**delete as applicable