**SERVICE QUESTIONNAIRE: COMMUNITY PHARMACY**

**Provider Information**

1. Provider Name:
2. Main contact for PH services (name/title):
3. Address:
4. Telephone:
5. E-mail

**Service Information**

Please answer the following questions:-

|  |  |
| --- | --- |
| 1. Please indicate which service you wish to provide
 | Yes/No |
| * Lot 1: Sexual Health services in Community Pharmacy, including EHC
 |  |
| * Lot 2: Stop Smoking support in community pharmacy
 |  |
| * Lot 3: Provision of flu vaccine for Council staff (voucher scheme)
 |  |
| 1. Will all staff providing these services meet the competency requirements outlined in individual service specifications?
 |  |
|  |  |
| 1. Will the provider meet all quality requirements outlined in individual service specifications?
 |  |

Please note that all questions are mandatory. Providing the answer **NO** to questions **7 & 8** will result in an automatic fail meaning you will **NOT** awarded a place on the Framework.

**Delivery locations**

1. On the table overleaf, please list all fixed sites that you provide services from and indicate which services you wish to provide from each location).

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| --- | --- | --- | --- | --- |
| Site address | Pharmacy Code(F number) | Sexual Health/EHC | Stop Smoking | Flu Vaccine |
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