

**Chapter 36**

**Annex 14**

**Notification of unplanned temporary suspension of services**

**Name of contractor**

**ODS code (also known as the F code)**

**Full address of premises to which the application relates**

**Address for correspondence (if different)**


Please set out the dates and times of the unplanned temporary suspension of pharmaceutical services.

Date(s) of the temporary suspension	Times at which pharmaceutical services were not provided

Please set out in the box below the reasons for the temporary suspension.

Please set out in the box below any actions taken to limit the impact on users of the premises.

If you are subject to a 100 hours condition, please set out in the box below how you will continue to be open for at least 100 hours per week (as required by regulation 65(2) of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended) in light of the unplanned temporary suspension of pharmaceutical services

Signature .....

Name .....

Position .....

Date .....

On behalf of .....  
(insert name of contractor)

Contact email address in case of queries .....

Contact phone number in case of queries .....