NATIONAL HEALTH FUND

6TH Floor, The Towers, 25 Dominica Drive, Kingston 5
Tel: (876) 906-1106 Fax: 906-1105 Toll-free 1-888-NHF-CARE
Website: www.nhf.org.jm

PHARMACEUTICAL DIVISION: Tel. (876) 923-6920/923-6926-8 Fax. 923 7159

PROVIDER APPLICATION CHANGE FORM

Kindly complete areas where applicable on the **CHANGE** form and return original to the above address along with **current applicable certified copies** of the following documents:

- Pharmacy Council Certificate of Registration of the Shop
- Pharmacy Council Certificate of Registration of the Registering Pharmacist
- Certificate of Business Registration - Registrar of Companies (*if applicable*)
- Certificate of Incorporation and Articles of Incorporation/Association/Memorandum of Association

N.B. Where there is a change of Directors, kindly submit supporting documents verifying this change

Indicate the change required

☐ **Change of Location** ☐ **Change of Ownership**
☐ **Change of Registering Pharmacist** ☐ **Change in Name of Existing Pharmacy**

PHARMACY INFORMATION

1). Name of Pharmacy: ____

2). TRN (business): ____

3). Pharmacy License Number: _________________________ **4). Date of Issue:** ___________________

5). Type of Pharmacy: Public ☐ **Private: - Professional** ☐ **Retail** ☐

6). Address of Pharmacy (Street and Number):____

____

7). Mailing Address (*if different from above*): ____

8). Telephone Number(s): Office: ________________ **Cell:** ________________ **Fax:** _______________

9). Email Address: __________________________ **10). Name of Software Provider:** _______________

11 (a). Name of Registering Pharmacist____

11 (b).Pharmacist Registration #: ____

11 (c). Previous Employment of Registering Pharmacist over the past two (2) yrs ____________________

____

OWNER/DIRECTORS INFORMATION

12). Name (s)	Tel. Number(s)	Occupation	Place of Employment	Email Address
________________	________________	________________	________________	____________
________________	________________	________________	________________	____________
________________	________________	________________	________________	____________
________________	________________	________________	________________	____________

13). Are you currently an owner of another Pharmacy? ☐**Yes** ☐ **No**

13(a). If yes, indicate name(s) ____

14). Have you previously owned a Pharmacy? ☐**Yes** ☐ **No**

14(a). If yes, indicate name(s) ____

15). Are these Pharmacies currently an NHF Card or JADEP Card Provider? ☐**Yes** ☐ **No**

16). Are you a Provider for any other Insurance Carrier/Private Plans? ☐**Yes** ☐ **No**

17). If yes, indicate name(s) ____

18). Preferred method of Communication: ☐ **Email** ☐ **Fax** ☐ **Mail**

Name of Applicant	Signature	Position	Date
______________________________	______________	_____________	________

(*Please print name*) Company Stamp/Seal

Signature of Referee (*Attorney-at-Law, Minister of Religion, J.P, Notary Public, Superintendent of Police*)

Name of Referee	Signature	Position	Date
______________________________	______________	_____________	__________

(*Please print name*) Company Stamp/Seal