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 FORM- Private Sector

Kindly complete the form and return original to the above address along with **current 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

Tick the appropriate box: ☐ **NHF Card** ☐ **JADEP**

PHARMACY INFORMATION

1). Name of Pharmacy: _____

2). TRN (business): _____ **(attach a copy) 3). Pharmacy Licence Number:** _____

4). Date of Issue: _____

5). Type of Pharmacy: **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). Name of Registering Pharmacist_____

12 (a). Pharmacist Registration #: _____

12 (b). Employment history of Registering Pharmacist over the past two (2) yrs _____

_____

OWNER/DIRECTORS INFORMATION

13). Name (s)	Tel. Number(s)	Occupation	Place of Employment	Email Address
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

14). Are you currently an owner of another Pharmacy? ○ **Yes** ○ **No**

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

15). Have you previously owned a Pharmacy? ○ **Yes** ○ **No**

15(a). If yes, indicate name(s) _____

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

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

18). (a) If yes, indicate name(s) _____

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

Name of Applicant	Signature	Position	Date
_____	_____	_____	_____

(*Please print name***)** *Company Stamp/Seal*

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*

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