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

- Pharmacy Council Certificate of Registration of the Shop
- Pharmacy Council Certificate of Registration of the Registering Pharmacist
- Certificate of Business Registration - Registrar of Companies
- **F23** Notice of Appointment of/change of Directors
- Certificate of Incorporation and Articles of Incorporation

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

Indicate the change required

☐ **Change of Location** ☐ **Change of Owner/Director(s)**
☐ **Change of Registering Pharmacist** ☐ **Change in Name of Existing Pharmacy**

PHARMACY INFORMATION

1). Name of Pharmacy: ______________________________

2). TRN (business): ______________________________

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). Pharmacist Registration #: ______________________________

12 (a). Employment history of Registering Pharmacist over the past two (2) yrs ______________________

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OWNER/DIRECTOR(S) 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

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

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