



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*)
- F23 Notice of Appointment of/change of Directors (*if applicable*)
- Certificate of Incorporation and Articles of Incorporation

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): _____ (copy required upon request)
- 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 _____

**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