GENERAL OPHTHALMIC SERVICES (GOS)

GOS Specialist Supplementary Service

STREAM A Application Form

This application form is to be used by an IP Optometrist who wishes to enter into an arrangement with a Health Board/Health Boards for the provision of GOS Specialist Supplementary.

---

* Fields marked with an asterisk (*) are mandatory, failure to complete these may result in the form being returned to the applicant.
For a Part 1 listing application, enter the relevant practice(s) details in Section B (for practice premises) and/or Section C (for mobile practices). For a Part 2 listing application, do not enter any practice details for the relevant Part 2 listed Board(s) in Sections B-C and instead select the relevant Part 2 listed Board(s) in section D.

SECTION A: IP OPTOMETRIST DETAILS:

*Forename

*Surname

*Prescriber Code

This information may be found on your NHS Scotland prescription pad, or via Ophthalmic Clinician Data Access (OCDA) application in TURAS.

*Ophthalmic List Number

*GOC Number

*Listing: Part 1 Part 2

Select one or both as appropriate

SECTION B: PART 1 PRACTICE PREMISES

For applications under **Part 1** listing status associated with a **practice premises,** please provide details of the specific location(s) from where GOS Specialist Supplementary will be provided (use the 'Additional Practice Addendum' form to list any additional practices):

Practice Name

Practice Address Line 1

Practice Address Line 2

Practice Town/City

Practice Postcode

Health Board

Select

Practice Payment Location Code

Practice Name

Practice Address Line 1

Practice Address Line 2

Practice Town/City

Practice Postcode

Health Board

Select

Practice Payment Location Code

Practice Name

Practice Address Line 1

Practice Address Line 2

Practice Town/City

Practice Postcode

Health Board
Select

Practice Payment Location Code

SECTION C: MOBILE PROVIDER

For applications under **Part 1** listing status associated with a **mobile provider**, please provide details of the Health Board(s) within which GOS Specialist Supplementary will be provided (use the 'Additional Practice Addendum' form to list any additional practices):

Mobile Practice Name

Mobile Practice Address Line 1

Mobile Practice Address Line 2

Mobile Practice Town/City

Mobile Practice Postcode

Health Board
Select

Practice Payment Location Code

Mobile Practice Name

Mobile Practice Address Line 1

Mobile Practice Address Line 2

Mobile Practice Town/City

Mobile Practice Postcode

Health Board
Select

Practice Payment Location Code

Mobile Practice Name

Mobile Practice Address Line 1

Mobile Practice Address Line 2

Mobile Practice Town/City

Mobile Practice Postcode

Health Board
Select

Practice Payment Location Code

SECTION D: PART 2 LISTING

For applications under Part 2 listing status, provide details of the Health Board(s) from where GOS Specialist Supplementary will be provided:

☐ Ayrshire & Arran ☐ Borders ☐ Dumfries & Galloway ☐ Fife ☐ Forth Valley

☐ Grampian ☐ Greater Glasgow & Clyde ☐ Highland ☐ Lanarkshire ☐ Lothian

☐ Shetland ☐ Tayside ☐ Western Isles

SECTION E - DECLARATION:

I confirm that the information contained within this application is correct and complete. I understand that, if it is not, appropriate action may be taken.

*Agree ☐

I confirm that in providing GOS Specialist Supplementary I will work within my own level of competence and experience, and in line with Annex C of the **Statement** issued by Scottish Ministers under regulation 17 of the **National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006**, as amended.

*Agree ☐

I confirm that I will fully comply with the Terms of Service applicable to GOS Specialist Supplementary as set out in the **National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006**, as amended.

*Agree ☐

(For Part 1 listed individuals only) For an application in relation to practice premises, I confirm that the location(s) set out in SECTION B meets the minimum requirement for equipment as set out in Appendix E of the **Statement** and that appropriate clinical waste management and disposal arrangements are in place. In addition, where it has been stated that domiciliary GOS Specialist Supplementary will be provided from this location(s), I confirm that the minimum requirement for equipment as set out in Appendix E of the **Statement** has been met.

For an application in relation to mobile providers, I confirm that the provider set out in SECTION C meets the minimum requirement for equipment as set out in Appendix E of the **Statement** and that appropriate clinical waste management and disposal arrangements are in place.

Agree ☐

The information you have provided within this application form will be used by NHS Scotland to carry out its various functions in relation to GOS Specialist Supplementary. Information relevant to this application will be held within the National Primary Care Clinician Database (NPCCD) and publicly available on NHS Inform.

I give my permission for NHS National Services Scotland and the Health Board(s) listed above to process the data contained within this application form.

*Agree ☐

*Date of declaration ☐

Completed forms **must** be emailed to NSS at ***NSS.psd-GOS-SS@nhs.scot*** from your **NHS email address.**