

GOS Specialist Supplementary Application Form Guidance

IMPORTANT. This application form **must be completed in full** (see full guidance pages 2–4 below). Forms **will** be returned if completed incorrectly.

Before submitting your form, please ensure you have filled in all required fields paying specific attention to the checklist below.

Part 1 ONLY

You will **only** provide GOS-Specialist Supplementary under Part 1 listing status. This means you are included in Part 1 of a Health Board’s ophthalmic list as having undertaken to provide general ophthalmic services from a specific practice premises or from the correspondence address of a mobile provider.

- Section A: *Listing has **only** Part 1 ticked ☐
- Section B&C: All required practice premises/ mobile locations have been entered.... ☐
- Section D: **No** Health Boards are ticked ☐
- Section E: ALL “Agree” boxes are ticked ☐

Part 2 ONLY

You will **only** provide GOS- Specialist Supplementary under Part 2 listing status. This means you are included in Part 2 of a Health Board’s ophthalmic list as an optometrist who has been approved to assist in the provision of general ophthalmic services. You are not regularly engaged for the provision of general ophthalmic services from a specific practice premises or from the correspondence address of a mobile provider.

- Section A: *Listing has **only** Part 2 ticked ☐
- Section B&C: **No** premises/ mobile locations have been entered..... ☐
- Section D: All Health Boards you will provide GOS-SS in as a Part 2 are ticked..... ☐
- Section E: All **except** fourth declaration “Agree” boxes are ticked..... ☐

Part 1 AND Part 2

You will provide GOS- Specialist Supplementary under **both** Part 1 and Part 2 listing status.

- Section A: *Listing has Part 1 **and** Part 2 ticked ☐
- Section B&C: All required practice premises/ mobile locations have been entered... ☐
- Section D: All Health Boards you will provide GOS-SS as a Part 2 in are ticked..... ☐
- Section E: All “Agree” boxes are ticked ☐

GOS Specialist Supplementary Application Form Guidance (Stream A)

Do NOT send this form by post.

Please ensure that this form is completed **digitally**. The completed form must be saved and then returned by email from your **individual** NHS.Scot email to our GOS Specialist Supplementary application team at: NSS.psd-GOS-SS@nhs.scot

In subject header of email please enter “GOS Specialist Supplementary Application Form” and Ophthalmic list number e.g “GOS Specialist Supplementary Application Form – 11111”

**** Fields marked with an asterisk (*) are mandatory. Failure to complete fully will 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). Do not tick any Health Boards in Section D for Part 1 listing only. 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.

IP Optometrist Details

Enter your Forename, Surname and Prescriber Code.

*Ophthalmic List Number

*GOC Number

*Listing: Part 1 ☐ Part 2 ☐
Select one or both as appropriate

Listing

Select 'Part 1' if you are on Part 1 of an Ophthalmic List in one or more Health Boards relevant to your application. Select 'Part 2' if you are on Part 2 of an Ophthalmic List in one or more Health Boards relevant to your application. Select both boxes if both are applicable.

Ophthalmic List Number Format

Please enter your five-digit Ophthalmic List Number without hyphens or spaces e.g. 12345

GOC Number Format

Please enter this in the following format with hyphens e.g. 01-23456

Note: The information submitted on this form will be validated against your details held on the National Primary Care Clinician Database (NPCCD). Please check your data, and update if inaccurate, on the [Ophthalmic Clinician Data Access \(OCDA\) application](#) in Turas before submitting this form.

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	<input type="text"/>
Practice Address Line 1	<input type="text"/>
Practice Address Line 2	<input type="text"/>
Practice Town/City	<input type="text"/>
Practice Postcode	<input type="text"/>

Practice Details

Please ensure that the address and the postcode are completed accurately and in full.

Health Board	<input type="text" value="Select"/>
Practice Payment Location Code	<input type="text"/>

Health Board Selection

Select the relevant Health Board that the practice is registered with, e.g. NHS Ayrshire & Arran. The dropdown will appear when you click in the field.

Practice Payment Location Code Format

Please enter the five-digit Practice Payment Location Code without hyphens or spaces e.g. 12345

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	<input type="text"/>
Mobile Practice Address Line 1	<input type="text"/>
Mobile Practice Address Line 2	<input type="text"/>
Mobile Practice Town/City	<input type="text"/>
Mobile Practice Postcode	<input type="text"/>

Practice Details

Please ensure that the address and the postcode are completed accurately and in full.

Health Board	<input type="text" value="Select"/>
Practice Payment Location Code	<input type="text"/>

Health Board Selection

Select the relevant Health Board that the mobile provider is registered with, e.g. NHS Ayrshire & Arran. The dropdown will appear when you click in the field.

Practice Payment Location Code Format

Please enter the five-digit Practice Payment Location Code without hyphens or spaces e.g. 12345.

Note: Additional practice premises and mobile providers can be added with the 'Additional Practice Addendum' form. This must be sent alongside a 'STREAM A Application' form with Section E - Declaration completed.

Note: Only complete for Part 2 Listings.

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:

<input type="checkbox"/> Ayrshire & Arran	<input type="checkbox"/> Borders	<input type="checkbox"/> Dumfries & Galloway	<input type="checkbox"/> Fife	<input type="checkbox"/> Forth Valley
<input type="checkbox"/> Grampian	<input type="checkbox"/> Greater Glasgow & Clyde	<input type="checkbox"/> Highland	<input type="checkbox"/> Lanarkshire	<input type="checkbox"/> Lothian
<input type="checkbox"/> Shetland	<input type="checkbox"/> Tayside	<input type="checkbox"/> Western Isles		

Part 2 Listing

Tick **each** Health Board in the area you are applying to provide GOS Specialist Supplementary as a Part 2 listed IP optometrist.

You should **only** select the Health Boards where you will be providing GOS Specialist Supplementary.

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 ☐

Declarations

Part 1 listed applicants: All "Agree" boxes **must** be ticked.

Part 2 ONLY applicants: All "Agree boxes, except the fourth declaration, **must** be ticked.

Part 1 and 2 listed applicants: All "Agree" boxes **must** be ticked.

For clarification on any legislation listed in Section E, please click on the hyperlink provided on the form.

*Date of declaration

Date of Declaration

Please enter the date of declaration in the following format: DD/MM/YYYY