**Termination of GOS Contract**

**I/we hereby give notice of termination of the below listed GOS contract.**

|  |  |
| --- | --- |
| Name of Contractor: |  |
|  | |
| Trading Name: |  |
|  |  |
| ODS code: |  |
|  | |
| |  |  | | --- | --- | | Address of Practice: |  | |  |  | | Telephone: |  | |  |  | | Forwarding Address: |  | |  |  | | Email address: |  | | | |

**Please tick the type of contract that you wish to terminate:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mandatory: |  |  | Additional: |  |

**Please complete the intended date of termination:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Termination: |  |  | / |  |  | / |  |  |  |  |

Where a contractor serves notice pursuant to sub-paragraph (1), the contract shall terminate on a date 3 months after the date on which the notice is served (“the termination date”), save that if the termination date is not the last calendar day of a month, the contract shall instead terminate on the last calendar day of the month in which the termination date falls**.**

**Please give your reason for terminating:**

|  |  |
| --- | --- |
| Reason for Termination: |  |

**Please indicate what type of organisation you are:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Individual: |  |  | Partnership: |  |  | Body Corporate: |  |

|  |  |
| --- | --- |
| Limited Liability Partnership (LLP): |  |

**Please tick which of the below applies:**

|  |  |
| --- | --- |
| Premises is fully closing: |  |

|  |  |
| --- | --- |
| Premises is remaining open either for private and/or dispensing only patients: |  |

|  |  |
| --- | --- |
| Premises is remaining open as part of a takeover: |  |

**Patient Records**

Contract requires records to be kept for minimum 7 years however, Professional recommendations are to keep records for longer, i.e., adults and deceased patients: 10 years; children to 25th birthday.

**Professional Indemnity**

It is recommended that Professional Indemnity is to be held for 7 years post retirement i.e., the length of time a patient can pursue a claim.

**Public Liability/Employers Liability Insurance**

It is essential that the current contractor maintains insurance cover for practices that continue to deliver GOS until a new contractor takes over.

I confirm that I am aware of the minimum contractual requirement to keep patient records as overleaf and am aware of the recommendations to maintain Professional Indemnity.

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| Patient records are to be kept by the contractor as detailed overleaf: | | | | Yes |  |  |  | No |  | |  |
|  | | | | | | | | | |
| If yes, where are these to be stored? | |  | | | | | | | |
|  | | | | | | | | | |
| Patient records are to be held by another contractor: | | | | Yes |  |  |  | No |  | |  |
| **If yes, please give details of the contractor:** | | | | | | | | | |
|  | Name: | |  | | | | | | |
|  | |  | | | | | | |
| Trading Name: | |  | | | | | | |
|  | |  | | | | | | |
| Address: | |  | | | | | | |
|  | |  | | | | | | |
| Postcode: | |  | | | | | | |
|  | |  | | | | | | |
| Tel No: | |  | | | | | | |
|  | |  | | | | | | |
| Email Address: | |  | | | | | | |
|  |  | |  | | | | | | |

**Please confirm how you will be informing your patients of where their records are being kept:**

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| Name of individual signing the request: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Position i.e., Owner/Director etc: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Signature: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Date: |  |  | / |  |  | / |  |  |  |  |  | |

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| Name of individual signing the request: |  | | | | | | | | | | |
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| Position i.e., Owner/Director etc: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Signature: |  | | | | | | | | | | |
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| Name of individual signing the request: |  | | | | | | | | | | |
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| Position i.e., Owner/Director etc: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Signature: |  | | | | | | | | | | |
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| Name of individual signing the request: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Position i.e., Owner/Director etc: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Signature: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Date: |  |  | / |  |  | / |  |  |  |  |  | |

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| Name of individual signing the request: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Position i.e., Owner/Director etc: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Signature: |  | | | | | | | | | | |
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| Date: |  |  | / |  |  | / |  |  |  |  |  | |

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| Name of individual signing the request: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Position i.e., Owner/Director etc: |  | | | | | | | | | | |
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| Signature: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Date: |  |  | / |  |  | / |  |  |  |  |  | |

Please note, in the instance of a body corporate or LLP, **all** directors must sign this termination form to process the contract termination.

Please return this form to [nhsbsa.pao-contractadmin@nhs.net](mailto:nhsbsa.pao-contractadmin@nhs.net) – or call NHSBSA Provider Assurance Ophthalmic (PAO) Contract Administration Team on 0300 330 9403 for   
any enquires.