**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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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:**

|  |
| --- |
|  |

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

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

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

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

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

|  |  |
| --- | --- |
| Name of individual signing the request: |  |
|  |  |
| Position i.e., Owner/Director etc: |  |
|  |  |
| 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 – or call NHSBSA Provider Assurance Ophthalmic (PAO) Contract Administration Team on 0300 330 9403 for
any enquires.