**COMMUNITY PHARMACY CLOZAPINE SERVICE**

**CONTRACT**

**CONTRACTOR CODE** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF PHARMACY** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHARMACY ADDRESS** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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The Pharmacy agrees to participate in the Community Pharmacy Clozapine Service in accordance with the guidance set out in the attached Specification.

**Signature** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Pharmacist Signature)

**Print Name** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NOTE: The Contract can be withdrawn by either party (the HB or pharmacy), by giving 3 months notice.

**Completed Contracts should be returned FAO:- Pamela Calder, Pharmacy Contracts Officer, NHS Forth Valley, Suite 2, Carseview House, Castle Business Park, Stirling, FK 4SW.**