**Voluntary removal of a pharmacy premises entry from the register**

### April 2025

**Use this form to remove your pharmacy premises from Part 3 of the register, if you no longer operate a retail pharmacy business at the premises.**

**Depending on the structure of the organisation, this declaration should be made by:**

• **the sole trader, who must be a currently registered pharmacist**

• **a member of a partnership who is a currently registered pharmacist**

• **a director of a body corporate, who has the authority to bind the body corporate**

• **a partner of a limited liability partnership (LLP), who has authority to bind the LLP**

• **the chief pharmacist of the NHS Trust**

## Pharmacy details

**Give the details of the pharmacy premises. You can find the registration details on myGPhCpharmacy.**

|  |  |
| --- | --- |
| Address |  |

|  |  |
| --- | --- |
| Post code |  |

|  |  |
| --- | --- |
| Trading name |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Premises registration number |  |  |  |  |  |  |  |
|

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Requested date of removal (DD MM YY) |  |  |  |  |  |  |
|

* 1. **What type of pharmacy do you want to remove from the register? (please tick only one)**

1. **a high street or community pharmacy**
2. **a hospital pharmacy**
3. **a prison pharmacy**
4. **a temporary pharmacy due to refurbishment**
5. **a mail order or online pharmacy**

## Contact details

**Give the details of the person we should contact about this removal, if we need to do so.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title | Mr |  | Mrs |  | Ms |  | Miss |  | Other |  |

|  |  |
| --- | --- |
| Name |  |

|  |  |
| --- | --- |
| Position |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| GPhC registration number  (if applicable) |  |  |  |  |  |  |  |
|

|  |  |
| --- | --- |
| Email |  |

|  |  |
| --- | --- |
| Phone |  |

## Pharmacy owner details

* 1. **Is the organisation submitting this removal:**

**a body corporate or limited liability partnership (LLP)  Please fill in section A**

**an NHS trust  Please fill in section B**

**a sole trader or partnership  Please fill in section C**

### Section A: Body corporate or LLP

|  |  |
| --- | --- |
| Organisation name |  |

|  |  |
| --- | --- |
| Organisation address  (as registered with Companies House) |  |

|  |  |
| --- | --- |
| Post code |  |

|  |  |
| --- | --- |
| Companies House number |  |

**A1. Give details of all the current directors of the body corporate or partners of the LLP.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** | **First name(s)** | **Surname or family name** | **GPhC registration number (if applicable)** |
|  |  |  |  |

|  |  |
| --- | --- |
| Superintendent name |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Superintendent’s GPhC registration number |  |  |  |  |  |  |  |
|

**Important:** If, following the removal of these pharmacy premises from Part 3 of the register, the body corporate or LLP no longer owns any pharmacy premises, the Superintendent Pharmacist must complete and submit a resignation of superintendent form to notify us that they are no longer carrying out that role for this organisation.

### Section B: NHS trust

|  |  |
| --- | --- |
| Organisation name |  |

|  |  |
| --- | --- |
| Address |  |

|  |  |
| --- | --- |
| Post code |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| GPhC owner number |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| Superintendent name |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Superintendent’s GPhC registration number |  |  |  |  |  |  |  |
|

**Important:** If, following the removal of these pharmacy premises from Part 3 of the register, the NHS trust no longer owns any pharmacy premises, the Superintendent Pharmacist must complete and submit a resignation of superintendent form to notify us that they are no longer carrying out that role for this organisation.

### Section C: Sole trader or partnership

**Sole trader or first partner**

|  |  |
| --- | --- |
| Name |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| GPhC registration number |  |  |  |  |  |  |  |
|

|  |  |
| --- | --- |
| Sole trader’s home address  (as in the GPhC register) **or**  partnership’s principal office address |  |

**Second partner (if applicable)**

|  |  |
| --- | --- |
| Name |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| GPhC registration number |  |  |  |  |  |  |  |
|

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| GPhC owner number |  |  |  |  |  |  |  |  |

## Reason for voluntary removal

* 1. **Why you are applying to remove the premises identified in section 1 from Part 3 of the register?**

**The pharmacy business has ceased trading altogether and closed these premises**

**The pharmacy business has relocated to new pharmacy premises and no longer trades from these premises**

**The pharmacy premises is the subject of regulatory investigations and proceedings by the GPhC and you wish these to be taken into account when this application is considered**

**Other: please give details:**

|  |
| --- |
|  |

## Declarations

**I declare that:**

* 1. I am applying for voluntary removal of pharmacy premises from Part 3 of the register as I will no longer be conducting a retail pharmacy business from the premises detailed in Section1 of this application form.
  2. I am not aware of any investigation by any enforcement or regulatory body other than the GPhC, or proceedings brought by such a body that relate to these premises.
  3. The information that I have provided in this application for voluntary removal is complete, true and accurate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |

Signed Date

|  |  |
| --- | --- |
| Name |  |

|  |  |
| --- | --- |
| Position |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| GPhC registration number (if applicable) |  |  |  |  |  |  |  |
|

Please email your completed form to [premises@pharmacyregulation.org](mailto:premises@pharmacyregulation.org).