## Application to the Pharmacy Team Relief Fund for community pharmacy assistance (Tranche 4)

**Please ensure you have read our
Pharmacy Team Relief Fund Policy and Process (Tranche 4)**

Working within the parameters of our agreement with the Ministry of Health, we are again seeking to provide relief for community pharmacy teams/team members.

Relief can be provided by a locum pharmacist and/or technician you know already or a pharmacist and/or technician suggested by us.

Following a successful application, and signed reimbursement agreement, the Fund will reimburse the pharmacy employer:

1. For a pharmacist providing relief, $55 per hour (plus GST where applicable)
2. For a technician providing relief, $27 per hour (plus GST where applicable)
3. For accommodation and food, for either a pharmacist or technician, a flat rate of $200 per person, per night allowance
4. For distances over 20km each way, to and from, the pharmacy, $0.79/kilometre in a private car (as per IRD rates)
5. For extensive travel, as agreed by us, reimbursement will be made to the employer when the invoice and required documents are provided to us with supporting travel receipts.

If you are a **pharmacist owner or employer** and would like to apply to the Fund, you may do so using the application form. If you are a **pharmacist employee** and believe you fulfill the criteria, after speaking with your pharmacy employer to establish their consent, please make a joint application.

Only one application per licensed premise for the fourth tranche, should be made. Council would like to disburse the benefits as widely as possible, while still maintaining the targeted criteria.

## Applicant

|  |  |  |
| --- | --- | --- |
| 1 | Pharmacist (your) Name |  |
| 2 | Pharmacy Council registration number |  |
| 3 | Applicant phone number and email |  |
| 4 | Pharmacy Name (**the application relates to this pharmacy license only**) |  |
| 5 | Full address  |  |
| 6 | Facility ID |  |
| 7 | Are you the employer or the employee? Please circle one | Employer Employee |
| 8 | Name of pharmacy employer (if not above) |  |
| 9 | Contact phone number and email address (if not above) |  |
| 10 | If you are the employee, do you consent to us contacting your employer? |  Y/N |

## Criteria

The application is for workload relief for a practising pharmacist(s), holding an APC expiry 31 March 2022, and pharmacy technicians, holding a level 5 certificate. Please respond with yes or no to the questions below and provide further information where requested. Please note, selecting ‘No’ does not necessarily exclude you from funding, it helps us to assess the need in your pharmacy.

We recognise the answers to some of these questions are subjective. The intent is to understand the environment and circumstances in which your pharmacy is providing services, in your own words.

|  |  |  |
| --- | --- | --- |
| 11 | The application is for an independent, or franchise holder, community pharmacy: | Y/N |
| 11a | * Have any of your pharmacists or technicians had to self-isolate? How many?
 | Y/N(number) |
| 11b | * Please estimate the percentage of your patients who identify as Māori
 |  % |
| 11c | * Please estimate the percentage of your patients who are Pacific peoples
 |  % |
| 11d | * Is your pharmacy in a high deprivation area?
 | Y/N |
|  | * Does your pharmacy provide opioid substitution treatment?
 | Y/N |
| 11e | * Does your pharmacy dispense Clozapine?
 | Y/N |
| 12 | Is the pharmacist(s) being relieved, an early career pharmacist(s)? (i.e., 10yrs or fewer since graduation) | Y/N |
| 12a | * Have you, or members of your pharmacy team, suffered symptoms of stress? Please indicate what those are:
 | Y/N |
| 12b | * Have you, or members of your pharmacy team, worked excessive hours over a prolonged period of time?

Please advise the number of hours and period of time | Y/N |
| 13 | Has the pharmacy employer had difficulty **finding** pharmacist or technician cover? | Y/N |

### Your pharmacy

|  |  |  |
| --- | --- | --- |
| 14 | How many FTE pharmacists work in your pharmacy? |  |
| 15 | How many FTE technicians work in your pharmacy? |  |
| 16 | Approximately, how many prescriptions do you receive a week? |  |

## Supporting information:

|  |  |
| --- | --- |
| 17 | Please describe briefly your pharmacy team’s workflow now, and how it has changed since Monday 16 August 2021, for example, changes in volumes of prescriptions, patient numbers, deliveries, administration, or complexities of prescriptions (up to 4 sentences). |
| 18 | Please describe if your pharmacy has had adverse staff issues resulting from the effects of the Covid-19 pandemic, for example, team member(s) have been unwell, had to self-isolate, had family crises/bereavement (up to 3 sentences) |

## Service request details

|  |  |  |
| --- | --- | --- |
| 19a | Are you able to arrange your own pharmacist(s) and technician(s)? | Y/N |
| 19b | Or would you like us to suggest a team to you? | Y/N |

|  |  |
| --- | --- |
| 20 | Please state the **total number of hours** of pharmacist services you are applying for: |
|  |
| 21 | Please state the **total number of hours** of technician services you are applying for: |
|  |
| 22 | If you are able to arrange your own pharmacist(s) and technician(s), please provide an estimate of any travel required by them, for example, rental car, flights. |
|  |
| 23 | If there is any other information you believe is relevant to your application, please include this to support your request. |
|  |

In order to complete your reimbursement claim, once pharmacist and/or technicians services have been provided, you will be asked to briefly outline how their services were used and which of your own pharmacy team roles benefited from the relief. (This information is part of Council’s reporting obligations to the Ministry of Health. Please note, no identifying details will be sent to the Ministry.)

**I,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, the pharmacy employer**, declare that all of the information in this application is true and correct.

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