# Pharmacy Team Relief Fund Application Form

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 should be made. Council would like to disburse the benefits as widely as possible, while still maintaining the targeted criteria.

## Applicant

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| 1 | Pharmacist name | |
| 2 | 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? Please circle one | Y/N |

## Criteria

The application is for workload relief for a practising pharmacist(s), holding an APC with an expiry of31 March 2023, and pharmacy technicians, holding a level 5 certificate. Please respond by circling ’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.

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| 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<br>(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 |
| 11e | Does your pharmacy provide opioid substitution treatment? | Y/N |
| 11f | Does your pharmacy dispense Clozapine? | Y/N |
| 12 | Is the pharmacist(s) being relieved, an early career pharmacist(s)? (i.e. 10 years 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? Please advise the number of hours and period. | Y/N |
| 13 | Has the pharmacy employer had difficulty finding pharmacist or technician cover? | Y/N |

## Your pharmacy

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| 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:

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| 17 | Please briefly describe your pharmacy team's workflow now, and how it has changed COVID-19, for example, changes in volumes of prescriptions, patient numbers, deliveries, administration, or complexities of prescriptions (up to 4 sentences). |

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| 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

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|---|---|---|
| 19 | Are you able to arrange your own pharmacist(s) and technician(s)? | Y/N |
| 19a | 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 can 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. |

To complete your reimbursement claim, once pharmacist and/or technician 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 provided to the Ministry.)

**I, _____, the pharmacy employer**, declare that the information in this application is true and correct.

Signature _____ Date _____