



# New Customer Verification Form (NCVF)

SOP Reference:	4.8 & 4.9		
Document Reference:	OPS-FORM-005	Document Version:	V12
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This form should be fully completed ELECTRONICALLY or in BLOCK CAPITALS. Please mark any fields that are not applicable to your operation as NOT APPLICABLE.

When returning completed form please scan and attach all relevant documentation as appropriate, e.g. GDP cert, HO license, VAT cert etc. This will avoid any delays in setting up your account and verifying you as a customer.

By filling in this form you agree to accept our T&Cs <https://oxfordpharmacystore.co.uk/terms-conditions-of-sale/>

Please scan and E-mail completed form back to: [ops.orders@oxfordhealth.nhs.uk](mailto:ops.orders@oxfordhealth.nhs.uk)

## CUSTOMER DETAILS: PAGES 1-6 TO BE COMPLETED BY CUSTOMER

Date:	
Formation of the Company: (please circle/highlight)	Limited/ Sole Trader/ Partnership/Charity/ NHS Trust/ Other (please state):.....
Company House Registration Number:	
Company VAT Number:	
Company House Registered Name:	
Trading as Name:	
Company House Registered Address:	
Post code:	
Invoice Address (if different to above):	
Post code:	
Contact name for payments/accounts/credit control:	



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Contact number/E-mail for payments /accounts/ credit control:	
Email Address to send invoices to: (Note: Invoice only be sent electronically via email)	
Company Website:	
Contact name:	
Position:	
Email contact (For recall purposes):	
Charity registration number:	
VAT exempt: (if yes, please attach the VAT exemption certificate with each order & with this form)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Delivery address:	
Post code: (Please note: must be the same as postcode used on registration with any legal / professional / regulatory body)	
Business activity (please mark relevant with X):	<input type="checkbox"/> Hospital – NHS England <input type="checkbox"/> Hospital – NHS Other (Scotland, Wales, NI) <input type="checkbox"/> Pharmacy <input type="checkbox"/> Wholesaler <input type="checkbox"/> International / outside EU <input type="checkbox"/> NHS sub-contracted service / Outpatients Pharmacy (Please attach CMU framework agreement price letter from associated NHS Trust) <input type="checkbox"/> Dentist <input type="checkbox"/> GP <input type="checkbox"/> Vet <input type="checkbox"/> Private (Hospital or clinic) <input type="checkbox"/> University <input type="checkbox"/> Charity <input type="checkbox"/> Optometrist / Ophthalmologist



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		<input type="checkbox"/> Home-care provider <input type="checkbox"/> Paramedic <input type="checkbox"/> Allied healthcare professional (e.g. Chiropodist, podiatrist, physiotherapist) <input type="checkbox"/> HM Prison Other, please specify:
<b>License/registration status (as applicable)</b>		
EUDRA:		
MHRA (WDA(H), site no.) <sup>1</sup> :		
GPhC Premises:		
GMC number:		
GDC number:		
GOC number:		
HCPC number:		
PSNI number:		
CQC – hospital/ GP/ other	Provider ID:	
	Location ID:	
	Date of last inspection	
NHS Inform (Scotland):		
HIW (Wales):		
HSCNI (Northern Ireland):		
RQIA (Northern Ireland):		

<sup>1</sup> WDA Licence to be attached



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Other (e.g. Gov.je; Gov.gg):	
HO license number (for ordering CDs only) <sup>2</sup> :	
RCVS:	
<b>Veterinary practices only:</b> I can confirm that all products ordered will be administered to specific animals in line with the cascade requirement under the Veterinary Medicines Directorate.	
<b>Print name:</b> <b>Signature:</b> <b>Date:</b>	
<b>NCVF completed on behalf of the organisation:</b> (Note: This person must have appropriate authority and responsibility to set up the account and confirm all information provided is accurate on behalf of the organisation)	
<b>Print Name:</b>  <b>Job Role:</b>  <b>Contact Email:</b>  <b>Contact Number:</b>  <b>Signed:</b>  <b>Date:</b>	

Oxford Health NHS Foundation Trust  
T/A Oxford Pharmacy Store  
Unit 7 MXL Centre  
Lombard Way  
Banbury  
OX16 4TJ  
Tel: 01865 904 141  
[www.oxfordpharmacystore.co.uk](http://www.oxfordpharmacystore.co.uk)

<sup>2</sup> HO Licence to be attached



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August 2024

Dear Sir / Madam

### Re: Supply of Unlicensed Medicinal Products

An unlicensed medicinal product for human use<sup>3</sup> (commonly described as a “special”) may only be supplied to meet the special needs of an individual patient, and should NOT be supplied where an equivalent licensed medicinal product can meet the special needs of the patient.

Responsibility for deciding whether an individual patient has “special needs” which a licensed product cannot meet is a matter for the doctor, dentist, nurse independent prescriber, pharmacist independent prescriber or supplementary prescriber responsible for the patient’s care. Examples of “special needs” may include an intolerance or allergy to a particular ingredient, or an inability to ingest solid oral dosage forms. The requirement for a “special need” relates to the special **clinical** needs of the individual patient. It does NOT include reasons of cost, convenience or operational needs.

As a UK licensed wholesale distributor of, amongst other products, unlicensed medicinal products, Oxford Pharmacy Store (OPS) must be satisfied as to the existence of a special clinical need for any unlicensed medicinal product supplied.

Due to the regulations, as an organisation that orders unlicensed medicinal products from OPS, either currently or in the future, could you please complete the attached form below and return it for our records.

Yours faithfully,



**Dr Nicola Mayes**

Responsible Person (RP)

**Oxford Health NHS Foundation Trust**

Oxford Pharmacy Store (OPS), Unit 42, Sandford Lane, Kennington, Oxford, Oxfordshire, OX1 5RP

<sup>3</sup> The manufacture and distribution of veterinary unlicensed medicinal products for animal use is subject to separate legislation

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**Supply of Unlicensed Medicinal Products Confirmation Form**

**MUST be signed by an appropriate, registered, professional (e.g. pharmacist, pharmacy technician, dentist etc.)**

I, ..... (insert name in capitals)

Title, Job Role and, if applicable, Appropriate Professional registration number:

.....

Confirm on behalf of, .....  
 (insert organisation name, *address including post code*)

Provide details below if you are signing on behalf of other pharmacies within this Group / Trust / Organisation:

.....

Telephone Number(s): ..... (insert organisation Tel No.)

Email Address(es): .....  
 (insert a generic or group email accessed by more than one individual or - at least 2 individual email addresses)

that the prescriber is aware of the following:

- Unlicensed medicinal products do not have a UK Marketing Authorisation (MA) - the prescriber must be aware of this.
- The prescriber(s) must be registered with an appropriate professional body within either the UK or the EU.
- The prescriber(s) will report any Adverse Drug Reactions (ADRs) to OPS (who, in turn, will contact the MHRA and the manufacturer).
- Where OPS stock two or more unlicensed medicinal products with the same drug, form and strength (but different manufacturers and, potentially, excipients) the customer will be asked to confirm the specific drug required by using the appropriate product code.
- OPS will assign this as the default product code to be supplied for all future orders, unless the customer requests otherwise. In the event that OPS is unable to offer the default product (for instance, due to supply issues), OPS will inform the customer, on receipt of an order, to ascertain whether or not the alternate product code is to be supplied in place of the default product.

Signature: ..... Date: .....

Please scan and return to:

Email: [ops.orders@oxfordhealth.nhs.uk](mailto:ops.orders@oxfordhealth.nhs.uk)

Please retain a copy for your own records.

If you have any queries, please contact us on: 01865 904 141.



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**FOR INTERNAL OPS USE ONLY**

**Finance Verification**

Charitable status checked and on file:  Yes  No  N/A

Research certificate checked and on file:  Yes  No  N/A

VAT Exemption certificate received and on file:  Yes  No  N/A

OW Tax Code:

OW Tax Rate:

OW Price List:

OW Customer Category:

OW Regional Purchasing Group:

OW CMU Trust Code:

**Finance Team signature & date**

**Print name:**   
**Signature:**   
**Date:**



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QGT Verification			
MHRA revoked/suspended list- Does name appear on this list (check back 6 months):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
MHRA cancelled/terminated list- Does name appear on this list (check back 6 months):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Copy of GDP Certificate added to file:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Copy of GMP Certificate added to file:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Copy of HO license added to file:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
QGT Customer Category:			
<b>QGT signature &amp; date:</b>			
<b>Print Name:</b>			
<b>Signature:</b>			
<b>Date:</b>			

RP Verification	
Customer verified	Yes <input type="checkbox"/>
<b>RP signature &amp; date:</b>	
<b>Print Name:</b>	
<b>Signature</b>	
<b>Date:</b>	

QGT Inputting	
Customer added to OW	Yes <input type="checkbox"/>
Account number allocated	
<b>QGT signature &amp; date:</b>	
<b>Print Name:</b>	
<b>Signature:</b>	
<b>Date:</b>	





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## CST Final checks

Customer added to OW accurately and PO processed Yes

### CST signature & date:

**Print Name:**

**Signature:**

**Date:**

## S&MT Final checks

Customer informed via email Yes

### S&MT signature & date:

**Print Name:**

**Signature:**

**Date:**

## Revision History

Revision	Description of Change
11	Creation of Document on new OPS-FORM template. Addition of field for customer account number and field for update of status to complete. Customer licence section updated.

Authored by: PRINTED NAME	Harriet Hughes	Authored by: SIGNATURE		Date:	07/11/2024
Approved by: PRINTED NAME	Natasha Arif	Approved by: SIGNATURE		Date:	18/12/2024
QGT Review by: PRINTED NAME	Chris Woodard	QGT Review by: SIGNATURE		Date:	09/01/2025