SOP Number/Version: 47.2 **SOP Name: Provision of an STI and HIV Screening Service**		
Pharmacy Name:		
Supervising Pharmacist Declaration: I confirm I have implemented this SOP, and its content reflects practice in my pharmacy.		
Name: _____	Reg No.: _____	Signature: _____
Pharmacy Staff Declaration: Please sign below to confirm that you have read and understood this SOP		
Name	**Date**	**Signature**