

E.T.P Nomination Form

Market Chemist. 91-93 Church Street, London, NW8 8EU.
Tel: 02077231944 Fax: 02077248074

Personal details:

Full name: _____

Full address: _____

Telephone: _____ Mobile: _____

Email: _____

Surgery Information:

Doctor's name: _____

Surgery name: _____

Surgery address: _____

- ☐ I would like Market Chemist to keep my repeat slip to order my medication on contact from myself or representative and collect either in person or by means of electronic transfer my prescription from my surgery. I will inform Market Chemist if I wish to make changes to this arrangement.
- ☐ I would like Market Chemist to collect, either in person or by means of electronic transfer, my prescription from my surgery. I will inform Market Chemist if I wish to make changes to this arrangement.

Are you the patient or the patient's representative providing these consents?

- ☐ **Patient**
- ☐ **Representative** (please note that by signing below you confirm that you are authorised to act on behalf of the patient and to give consent to the use of information as described in this form)

- **Representative's full name:** _____

- **Relationship to patient:** _____

Signature: _____

Date: _____