E.T.P Nomination Form

Bees Pharmacy. 261 Wick Road, London, E9 5DG.
Tel: 020 8985 5265

Personal details:

Full name: ____

Full address: ____

Telephone: _______________________ Mobile: _______________________

Email: ____

Surgery Information:

Doctor's name: ____

Surgery name: ____

Surgery address: ____

☐ **I authorise Bees Pharmacy to order my medication on contact from myself or my representative and collect my prescription from my surgery. I will inform the Pharmacy if I wish to make changes to this arrangement.**

☐ **I would like Bees Pharmacy to keep my repeat slip to order my medication automatically at the required interval and collect my prescription from my surgery. I will inform the Pharmacy if I wish to make changes to this arrangement.**

☐ **I would like Bees Pharmacy to collect, either in person or by means of electronic transfer, my prescription from my surgery. I will inform Bees Pharmacy 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:** _______________