E.T.P Nomination Form

Chel Pharmacy. 173 Great Portland Street, London, W1W 5PH.
Tel: 020 7323 4713 Fax: 020 7436 6189

Personal details:

Full name: _____

Full address: _____

Telephone: _____ Mobile: _____

Email: _____

Surgery Information:

Doctor's name: _____

Surgery name: _____

Surgery address: _____

☐ **I would like Chel Pharmacy 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 Chel Pharmacy if I wish to make changes to this arrangement.**

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