

# E.T.P Nomination Form

Regal Pharmacy. 48-50 Chatsworth Rd, Lower Clapton, London E5 0LP.  
Tel: 020 8985 2536

## **Personal details:**

Full name: \_\_\_\_\_

Full address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

## **Surgery Information:**

Doctor's name: \_\_\_\_\_

Surgery name: \_\_\_\_\_

Surgery address: \_\_\_\_\_

I authorise Regal 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 Regal 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 Regal Pharmacy to collect, either in person or by means of electronic transfer, my prescription from my surgery. I will inform Regal 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: \_\_\_\_\_