

# E.T.P Nomination Form

Shore Pharmacy. 79 Russell Lane, Whetstone, London, N20 0BA.  
Tel: 020 8368 3013 Fax: 020 8361 0974

## Personal details:

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

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

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

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

## Surgery Information:

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

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

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

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