# E.T.P Nomination Form

WellCare Pharmacy. 552 Holloway Road, London, N7 6JP
Tel: 020 7263 3152

**Personal details:**

Full name: _____

Full address: _____

Telephone: _____ Mobile: _____

Email: _____

**Surgery Information:**

Doctor's name: _____

Surgery name: _____

Surgery address: _____

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