# E.T.P Nomination Form

Trinity Pharmacy. 87 South Street, Bishop's Stortford, Hertfordshire, CM23 3AL
Tel/Fax: 01279 654171

**Personal details:**

Full name: _____

Full address: _____

Telephone: _____ Mobile: _____

Email: _____

**Surgery Information:**

Doctor's name: _____

Surgery name: _____

Surgery address: _____

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

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