

Access to Online Services

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|--------------------------|--|
| Patient Name | |
| Date of Birth | |
| Address | |
| Postcode | |
| Email address (required) | |
| Telephone/ Mobile | |

I wish to register for the surgery's online services. Please issue me with a user name and password for this.

My user name and initial password should be either:

- * Sent by post to my home address
- * Held for collection by me from the surgery

* (DELETE AS APPROPRIATE)

I understand I should keep my log in details secure to prevent anyone else logging in on my behalf (except children under 13 years of age) and will notify the surgery in the event of this information becoming lost or compromised.

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Patient Signature/Parent (if patient under 13)

If patient under 13 years old:

Full Name of person signing

Relationship to patient

PLEASE NOTE: Applicants must attend the surgery in person with photo identification to register for online services eg Passport or Driving licence

FOR INTERNAL USE ONLY: READ CODE XaC7U

Identification provided _____

Initials _____