**Chilwell Valley and Meadows Medical Practice**

**Application for Access to General Practice Online Services**

Please complete the following in block capitals:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname |  |  | First name |  |
| Date of birth |  |  | Email address |  |
| Address |  |  |  |  |
| Postcode |  |  |  |  |
| Phone No (home) |  |  | Phone No (mobile) |  |

I wish to access the general practice online services selected below and agree to the following conditions

|  |
| --- |
| 1. I have read and understood the information leaflet provided by the practice
 |
| 1. I will be responsible for the security of the information that I see or download
 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 |
| 1. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible
 |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

In order to keep your records as secure as possible please select **only** the services that you wish to use by ticking the appropriate boxes:

|  |  |
| --- | --- |
| Booking appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |

You are also able to view your medical record online, if you would like this please ask Reception.

### For practice use only

|  |  |  |
| --- | --- | --- |
| EMIS No:  |  |  |
| Identity verified through(tick all that apply) | Vouching 🞏Vouching with information in record 🞏 Photo ID 🞏Proof of residence 🞏 | Date:  |
| Name of person who validated ID |  |  |
| Date account created  |  |