Penicuik Medical Practice

Application for Online Access – Please provide proof of ID with this Application Form

Surname	Date of Birth
First name	
Address Postcode	
Preferred Email address (not shared):	
Preferred Mobile Number: Text Messaging Reminders Yes ☐ No☐	Landline Number:
Preferred Pharmacy:	Rowlands Prec / Rowlands Edin Rd / Lloyds/ Lloyds Sainsburys / Roslin Pharmacy

I wish to have access to the following online services (please tick all that apply): YES NO

1. Requesting repeat prescriptions (**Please be aware that this will take 5 working Days to process**)	☐ ☐

I wish to use Online Services.
Please read each statement carefully and tick before signing. YES NO

1. I will be responsible for the security of the information that I am given in the letter with my registration details.	☐ ☐
2. If I choose to share my information with anyone else, this is at my own risk	☐ ☐
3. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐ ☐

I understand and agree with all the above statements:

Signature	Date

For practice use only

Patient CHI number		Vision ID number: 33370
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ **Photo ID and proof of residence ☐**
Authorised by **(#91B)**		Date
Date account created		
Date registration letter/email sent		