

EMIS Access Application Form

Patient to complete:

Name:	
D.O.B:	
Address:	
Tel No:	
Mob No:	
E-mail address:	
Practice Guidance read and understood	Delete as appropriate Yes/No

Surgery Staff Only

Proof of ID given e.g. Passport, utility bill, driving license:	Yes/No
Identity Confirmed:	Yes/No
Means of Identity e.g. utility bill etc	

I am the patient

I am representing the patient (with their authority, if over 16 yrs old)

(If representing the patient the patient you are representing should sign below and you should bring proof of their signature e.g. driving license, student card, etc)

Patients Signature _____

Date _____