Please complete this form and return it to the Surgery

Name	

Home Address	
Mobile Tel No	

Postcode		**Date of Birth**	

Can we post your medication through your letterbox if you are not home? Yes ☐ No ☐

Would you like us to text you with a expected delivery date? Yes ☐ No ☐

By signing this form I give consent to Bottisham Medical Practice to deliver my medication and understand Pro-Delivery software is used to ensure safe transit of medication and secure delivery. Deliveries will continue until such time as alternative instructions are provided to the practice.

We respect your privacy. We will only use your personal information in line with our privacy policy (full policy can be found on our website)

Signature ……

Date ……