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**REGISTRATION FOR PATIENT ACCESS ONLINE**

Name ………………………………………………………………...DOB……………………………

Address…………………………………………………………………………………………………

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I wish to be registered to use Access Online for requesting my repeat medication and using the online appointment booking facilities. I understand that the password and username that I am issued with are to be kept securely.

Please note:

* You are not able to request contraceptive or hormone replacement therapy medication.
* You may not request medication more than 7 days ahead of their due date.
* We require two forms of identification in order to provide you with your username and password. One must be photographic (such as a valid passport/driver’s license) and the other to prove you are living at above address (such as a recent utility bill or bank statement).

I understand that if I misuse this service (for example repeatedly requesting prescriptions that I do not need), the practice has the right to remove my registration for Access Online.

Signed………………………………………………………………………………………………….

(Please print name)………………………………………………………………….........................

Date………………………………………………………………………………………………….

In the case of a child 15 and under, please see your GP

…………………………………………………………………………………………..

For office use only:

Please state type of photographic ID……………………………………………………………….

Please state type of living address ID………………………………………………………………

Checked by (print name)………………………………………………………………………………

Signed**……………..……………………………………………………………………**