

**Whitesands Medical Practice**

**Application for Online Access**

Surname	Date of birth
First name	
Address	
Postcode	
Preferred Email address (not shared):	
Telephone number	Preferred Mobile number

**I wish to have access to the following online services (please tick all that apply):**

1. Cancelling / viewing appointments only (booking not available as yet)	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Requesting acute prescriptions	<input type="checkbox"/>

**I wish to use Online Services. Please read each statement carefully and tick before signing.**

1. I have understood the information provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>
6. I have 2 forms of proof of identification ( to be verified by reception)	<input type="checkbox"/>

**I understand and agree with all the above statements:**

Signature	Date
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**For practice use only**

Patient CHI number	Vision ID number	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> <b>Photo ID and proof of residence <input type="checkbox"/></b>
Authorised by	Date	
(#91B)		
Date account created		
Date registration letter/email sent		