APPLICATION FORM

BUCKINGHAM TERRACE MEDICAL PRACTICE
ON LINE ACCESS
APPLICATION

Name	
Address	
Date Of Birth	
Tel No.: **Mobile No:**	

For Staff use:

Proof of Identification	

I have read and understood the Practice Policy on the use of "On Line Access" and understand that failure to adhere to the guideline will result in immediate suspension of my account.

Signature _____

Date _____

Once your application is received, you can log in via the surgery website to register your "online access" facility.