CROWN HOUSE
SURGERY

Retford Primary Care Centre
North Road
Retford
Nottinghamshire
DN22 7XF
Tel: 01777 703672
Fax: 01777 710534
www.crownhousesurgery.co.uk

To be completed by the patient:

I, (please print full name)……., Date of Birth, ……..., patient at Crown House Surgery, request access to use SystmOne online functions and have presented photographic identification in order to prove my identity.

E-mail Address:…….....,…….

Mobile Phone Number:……

Patient's Signature:……..……

Date:

To be completed by CHS staff member:

I, (please print full name)……., member of staff working at Crown House Surgery confirm that I have seen and checked the photographic identification for the above named patient and confirm that they are who they say they are and that their details match those within SystmOne.

Documents checked: Passport ☐

Driving Licence ☐

Other, please state: ……

Staff Member's Signature: ……..

Date: