WOODLANDS SURGERY

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EMIS Access Application Form

Patient to complete:

Name:	
D.O.B:	
Address:	
Tel No:	
Mob No:	
E-mail address:	

I am the patient ☐

I am representing the patient (with their authority, if over 16 yrs old) ☐
(If representing the patient the patient you are representing should sign below and you should bring proof of their signature e.g. driving license, student card, etc)

I ______________________________________ have understood and will adhere to the Practice Guidance for the use of EMIS Access. I understand that failure on my part to adhere to the guidance may result in my EMIS Access registration being terminated. I understand that this will in no way affect my registration with the practice.

Patients Signature ____

Date ____