

# E.T.P. Consent Form

**Name:** .....

**Address:** .....

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**G.P./Practice:** .....

I wish to nominate Lafford Chemist as the pharmacy to receive my NHS ETP Prescriptions.

**Signed**

**Dated**

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Please complete and send to:

Lafford Chemist, 6-8 The Broadway, Plough Lane, Surrey, CR04QR