# OVER THE COUNTER FORM

| | | |
|---|---|---|
| Patient Name | | |
| Date of Birth | | |
| Contact Telephone Number | | |
| May a message be left? | **YES** ○ | **NO** ○ |

Please state below exactly what you are requiring? You must complete your own claim form with your personal details. It is your responsibility to provide as much information as possible to complete your request. This may include travel dates, illness dates, if you were hospitalised and length of stay, nature of illness/condition leading to the request.

**Failure to complete the necessary information could result in a delay for your request.**

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| **Fee Received** !! | |

**PLEASE READ CAREFULLY**

**By signing this form, you are aware that there is a fee for this private service, which you are obliged to pay in full at the time of request**. You will be informed if there is further payment required prior to collection of your request. **PLEASE NOTE: THERE IS AN ESTIMATED TURNAROUND TIME OF 3-4 WEEKS**. If you have not heard from us after 21 days, please contact SMG and ask to be put through to the Secretary.

| | |
|---|---|
| Signed | |
| Dated | |

When completed please hand it in to:

Sleaford Medical Group, 47 Boston Road, Sleaford, NG34 7HD

OR

Submit via the practice website: www.sleafordmedicalgroup.co.uk/medical-forms

*PLEASE NOTE* the fee will need to be paid prior to commencement of work

| | | | |
|---|---|---|---|
| Rec Ints | | Date | |

Jan 2021