**To be completed for patients who are exempt from NHS Prescription Charges**

**Community Pharmacy Optometry Supply Service (CPOSS)**

Cannock Chase CCG 

North Staffordshire CCG

South East Staffordshire & Seisdon Peninsula CCG

Stafford and Surrounds CCG

Stoke-on-Trent CCG

**Practice Name…………………………………………………………………………………………….**

**Practice Address Practice Phone Number**

**………………………………………………………………… ……………………………………………………………………**

**…………………………………………………………………**

**…………………………………………………………………**

**To the Pharmacist.**

**Please supply to:**

**Patient Name ……………………………………………………… Patient Date of Birth ………………………………**

**Patient address**

**…………………………………………………………….**

**……………………………………………………………**

**…………………………………………………………..**

**Preparation Required:**

**……………………………………………………..**

**Optometrist Signature …………………………………………………… Date …………………………………**

**Practioner GOC No ………………………………….**

*Written Oeder in accordance with Section 5 of Schedule 5, article 11(1)(a) of Statutory Insunstrument 1997 No 1830 as amended by Section 8 of Stautory Instrument 2005 No. 76*

**Patient Name …………………………………………………………….. Date of Birth ………………………………**

**The Patient does not pay because:**

|  |  |  |
| --- | --- | --- |
| **A** |  | **is 60 years of age or over or is under 16 years of age** |
| **B** |  | **is 16, 17 or 18 and in full-time education** |
| **D** |  | **has a valid maternity certificate** |
| **E** |  | **has a valid medical exemption certificate** |
| **F** |  | **has a valid prescription pre-payment certificate** |
| **G** |  | **has a prescription exemption certificate issued by Ministry of Defence** |
| **L** |  | **has an HC2 (full help) certificate** |
| **H** |  | **entitled to Income Support (IS) or Income-related Employment and Support Allowance (ESA)** |
| **K** |  | **entitled to Income-based Jobseeker’s Allowance (JSA)** |
| **M** |  | **has a Tax Credit Exemption Certificate** |
| **S** |  | **has a Pension Credit Guarantee (including partners)** |
| **U** |  | **Entitled to Universal Credit and meets the criteria** |

 **The information I have given is correct and complete and I confirm proper entitlement to exemption**

 **I am the patient I am the patient’s representative**

To be completed by the patient / patient’s representative

I received ……. (insert number) medicine(s) from this pharmacy

**Signed ………………………………………………………………………………….. Date ……………………………**

 **Was evidence of exemption seen? Yes? No?**