FW8 Application for prescription charge exemption (maternity)

This form will be processed more quickly if you fill it in using BLACK INK in BLOCK CAPITALS inside the boxes

Maternity Exemption

Dear Doctor, Midwife, Health Visitor or Nurse, please keep these forms in a safe place. When pregnancy is confirmed, or if the patient has had a baby in the last 12 months, they may get free prescriptions. However, they must have a valid maternity exemption certificate before they are entitled to free prescriptions. The patient should use this form to apply for an exemption certificate.

The patient should fill in **Part 1** and **Part 2**. You should complete **Part 3**. When completed send the form to: NHS Business Services Authority, Prescription Exemption Applications, Bridge House, 152 Pilgrim Street, Newcastle upon Tyne NE1 6SN, in the envelope provided.

Note: Your certificate will start one month before the date on which we get this form.

Part 1 ABOUT YOU

Title: Mrs Miss Ms Other

Surname:

First name:

House No/Name:

Street:

Town:

Postcode: Date of Birth (IMPORTANT): D D M M Y Y

Telephone number in case we need to contact you:

Email address:

NHS number (from your medical card):

Part 2 ABOUT YOUR PREGNANCY OR CHILD

I declare that my baby was born on, or is due on: D D M M Y Y

PATIENT DECLARATION

This is my application for a prescription charge maternity exemption certificate. I understand that the information I have provided will be used by the health services to check for fraud and incorrectness and to secure the effective and efficient delivery of prescribing and dispensing services. I understand this means that relevant information from this form will be disclosed to and by the NHS Business Services Authority, Department of Health, NHS England, NHS Protect and the Health and Social Care Information Centre and bodies performing functions on their behalf, and to the extent I need to I consent to this. I understand that the NHS Business Services Authority will use the information to process my application. They will not transfer my personal data outside of the European Economic Area. They may contact me to discuss my application and the quality of the service. My personal data will be deleted no later than 24 months after the certificate expires. Further details at www.nhsbsa.nhs.uk/privacypolicy.aspx. **I declare that the information I have given on this form is correct and complete and I understand that if it is not appropriate action may be taken.** NOTE: If the patient is unable to complete the form themselves the doctor, nurse, health visitor or midwife (or a member of the practice) can do so on the patient's behalf and they must print their name in the patient signature box below and complete Part 3.

Signature Date D D M M Y Y

Part 3 DOCTOR'S, MIDWIFE'S, HEALTH VISITOR'S OR NURSE'S STATEMENT

I confirm that the information given in Part 1 is in accordance with the patient's records and the information given by the patient in Part 2 is correct.

Signature Date D D M M Y Y

Midwife/Health Visitor/Nurse's UKCC Number:

GP's name (if none, write 'NONE'):

Address:

Postcode:

GP's or hospital doctor's stamp; or service doctor's name, rank, and establishment:

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