PLEASE COMPLETE IN BLOCK LETTERS FORM FP58 (Rev 2002)

APPLICATION FOR A CHILD TO JOIN A DOCTORS LIST

NHS Number					
Date of birth					
Child's forenames					
Child's surname					
Sex					
Issued by the Registr	Issued by the Registrar for the Sub-District of				
IMPORTANT NOTICE TO PARENT OR GUARDIAN					
 Where this form bears the National Health Service Number of the child named above. It will be necessary to quote this number when using NHS medical, dental or optical services. If you wish to register the child with a doctor under the NHS, you should fill in the details below and hand the form to the doctor of your choice as soon as possible. If you don't wish to register the child with a doctor under the NHS, you should keep this form in a safe place in case at any time in the future you decide to do so or the child needs to use the NHS dental or optical services. TO BE COMPLETED BY THE PERSON REGISTERING THE CHILD					
	Address				
Tolor	phone number	Postcode			
1010	nione number				
	ister the child r or both boxes	for general medical services for child health surveillance			
	Signatura	i for child health surveillance			
	Signature				
Relationship ("parent",	"guardian" etc)				
	Date				

TO BE COMPLETED BY THE D	OC.	TOR
Doctor's surname and initials		
PCT Code number		
I declare that		I am prepared to accept the patient overleaf for general medical services with:
		myself
		Dr , who is a
		member of this practice, and on whose behalf accept the patient
		(If the child health surveillance is to be provided) chi health surveillance will be provided to the child under five years named on this form in accordance with the programme agreed between the SHA and PCT by doctor on the PCT's child health surveillance list, name
		myself
		Dr , who is a
		member of this practice, and on whose behalf accept the patient
		drugs will be dispensed for this patient
		rural practice payments are claimed for this patient. The number of miles between the main surgery of the doct accepting the patient and the patients home is
		I understand the information on this form is correct
Doctor's signature		
Date		
FOR PCT USE ONLY		
		Patient registered for:-
		General Medical Services
		Child Health Surveillance
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