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GMC 4534279

SystmOnline application form

Name.....

Address.....
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.....
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D.O.B.....

Date of application.....

Please issue a password to enable to me access the Systm On-line website. I am fully aware of the following conditions

- I accept responsibility for the password and any access to the system using that password.
- I am aware that if I divulge the password to other parties they will be able to access information about me and parts of my medical history.
- I agree to inform the practice immediately if I believe my password has been lost/stolen
- I understand that Cliff Villages Medical Practice can cancel my access (without notification) if there is any kind of abuse of the system such as:

Booking appointments and not attending/Repeatedly booking and then cancelling appointments/Repeatedly requesting prescriptions that I do not need.

(Please note, this form will not be processed without proof of ID, please could you ensure you bring your ID in with you when you return the form)

Signed.....

For Surgery Use Only
Identification produced.....
Member of staff present.....
Password issued (date) .....