# Private Work Request Form

Please complete this form and hand it in to Reception with any additional documents. We will endeavour to provide you with a price for the work within 10 working days. Once payment is made we will process your request as specified below and will be able to provide you an estimated completion date.

EXAMPLE COSTS\* Medical Report (no assessment) £67.00- £89.50

Medical (Assessment & Report) £135.00

Private Sick Note £45.00

Private Letter £45.00

Passport Form and Photograph £42.00

Freedom from Infection Certificate £45.00

*\*****Certain procedures may not be included in the cost of a medical examination. For example: blood tests, x-rays and some vaccinations. Costs above are examples only. Costs will vary depending on work required.***

|  |  |
| --- | --- |
| Date of Request | <Today's date> |
| First Name | <Patient Name> |
| Last Name | <Patient Name> |
| Date of Birth | <Date of Birth> |
| Address | <Patient Address> |
| Tel No. | <Patient Contact Details> |
| Email | <Patient Contact Details> |
| **Preferred Contact Method**:  Telephone SMS  (please tick one)  Email Letter | |

## Request Details

## Details of work required:

Insurance Report Health Report  Medical   Copy of Medical Records  Vaccination Record  Sign Passport

Other *Please specify*: ………………………………………………………………………..............

Name of Company (if applicable): ………………………………………………………………………………………..

Additional Details ………………………………………………………………………………………………………………..

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|  |
| --- |
| **Do you want to see the completed work before it is sent or collected?**:  YES NO  not applicable |

## Collection

Please tick one collection method only and ensure you complete the necessary further information below

**Preferred Collection Method:** Email  Post  Collecting in person

**Email Address** please specify): ……………………………………………………………………..

**Postal Address**:  as above

Other (please specify)……………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………….

**Collecting in Person:** Please bring photographic identification with you. If it is to be collected by another individual please provide details below and ensure they bring identification with them.

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Address |  |

## Payment

|  |
| --- |
| **Preferred Payment Option**:  Bank Transfer (BACS) Cash Cheque.  (Payment must be received before work is completed) |

## DECLARATION

|  |  |
| --- | --- |
| I confirm that I am requesting the release of my medical records/information as specified above. | |
| Print Name |  |
| Signature |  |
| Date |  |

## *For Office Only:*

Received By…………………………………………………………………………………………………………………………

Date ……………………………………………………………………………………………………………………………………

updated 26.7.2016