**Application for Prepayment Prescriptions for Care Leavers**

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| --- | --- |
| First Name: |  |
| Last Name: |  |
| DOB: |  |
| Address (*current*), including postcode: |  |
| Email Address: |  |
| Telephone Number: |  |
| NHS Number (if known): |  |
| General Practitioner (*GP)* |  |
| General Practitioner (GP)Address, including postcode |   |
| Name of After Care Personal Advisor: |  |
| Personal Advisor Contact Details:*(Telephone Number)*: |  |
| Which Local Authority looked after you: |  |

**(I consent to Greater Manchester Integrated Care Board using my personal details to purchase a prepayment certificate for prescriptions and monitoring purposes)**

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| --- | --- | --- |
| Name:  | Signature: | Date: |

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| For Office use onlyPrescription approved for: - 3 months/12 months, Signed …………………………………………………… Name ………………………………………………………………. Date ……………….………………….on behalf of GM ICB |