**WALSALL HEALTH AUTHORITY**

DOCTORS NOTIFICATION OF CHANGE OF NAME AND/ OR ADDRESS

**PLEASE USE BLACK INK**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Doctor: |  | Date: |  |
| Name |  |
| New Name: |  | Old Name: |  |
| New Address: |  | Former Address: |  |
|  |  |
|  |  |
| Post Code: |  | Post Code: |  |
| Date of Birth: |  | Telephone Number: |  |
| NHS No: |
| **FOR OFFICE USE ONLY:**Proof of address taken & copied:  | Is the doctor willing to retain the patient on the list at the new address: | **YES** | **NO** |
| **Reason for wanting to stay on the practice list if out of area:** |
| **Signed:** |

**ANY PATIENT ACCEPTED ONTO THE PRACTICE LIST LIVING OUTSIDE THE PRACTICE BOUNDARY WILL HAVE THEIR HOME VISIT REQUIREMENTS PROVIDED BY A GP IN THEIR AREA AND NOT BY BLOXWICH MEDICAL PRACTICE.**