**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.**