

TEMPORARY RESIDENT / EMERGENCY TREATMENT FORM:

Please PRINT in BLOCK CAPITALS

Surname:

Forename:

Date of Birth:.....

Temporary Address:.....

.....

Postcode:

Contact telephone number:

Home Address :

.....

Post Code:

Registered GP:

Surgery Name:

Address :

How long are you staying in the area?

Less than 15 days or More than 15 days

Date of Appointment: **GP Initials :**

I hereby give permission for information to be shared with Kingussie Medical Practice from my registered Surgery.

Signed:.....