Registration Form

SECTION 1: PRACTICE INFORMATION

PRACTICE NAME _____

ADDRESS* _____

_____

_____ Post Code _____

MAIN CONTACT* _____

CONTACT NUMBER* _____

BUSINESS EMAIL* _____

WEBSITE _____

GOC REGISTRATION NUMBER* _____

VAT REG NO (IF APPLICABLE) _____

SECTION 2: DECLARATION

WE HEREBY SIGN UP TO DELIVER THE FOLLOWING 5 EYE PROMISES FOR ALL OF OUR PATIENTS

- [ ] WE PUT LONG TERM EYE HEALTH CARE FIRST
- [ ] WE GIVE PATIENTS AS MUCH TIME IN THE CONSULTANCY CHAIR AS THEIR INDIVIDUAL NEEDS REQUIRE
- [ ] WE WILL ALWAYS TRY TO OFFER REPEAT APPOINTMENTS WITH THE SAME PRACTITIONER
- [ ] WE WILL USE STATE OF THE ART IMAGINIGN EQUIPMENT AS A WAY OF MONITORING LONG TERM EYE HEALTH
- [ ] WE WILL ONLY RECOMMEND EYEWEAR THAT WILL BENEFIT PATIENTS

SIGNED _____ NAME _____

POSITION _____ DATE _____

Eye Practice

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