# Private Work Request Form

Please complete this form and hand it in to Reception with any additional documents. We will endeavour to provide you with a price for the work within 2 working days. Once payment is made we will process your request as specified below and will be able to provide you an estimated completion date.

EXAMPLE COSTS\* Medical Report (no assessment) £58.50 – £88.50

Medical (Assessment & Report) £127.00

Private Sick Note £30.00

Private Letter £30.00

Passport Form and Photograph £42.00

Freedom from Infection Certificate £32.00

*\*Certain procedures may not be included in the cost of a medical examination. For example: blood tests, x-rays and some vaccinations. Costs above are examples only. Costs will vary depending on work required.*

|  |  |
| --- | --- |
| Date of Request |  |
| First Name |  |
| Last Name |  |
| Date of Birth |  |
| Address |  |
| Tel No. |  |
| Email |  |
| **Preferred Contact Method**:  Telephone SMS  (please tick one)  Email Letter | |

## Request Details

## Details of work required:

Insurance Report Health Report  Medical   Copy of Medical Records  Vaccination Record  Sign Passport

Other *Please specify*: ………………………………………………………………………..............

Name of Company (if applicable): ………………………………………………………………………………………..

Additional Details ………………………………………………………………………………………………………………..

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|  |
| --- |
| **Do you want to see the completed work before it is sent or collected?**:  YES NO  not applicable |

## Collection

Please tick one collection method only and ensure you complete the necessary further information below

**Preferred Collection Method:** Fax  Post  Collecting in person

**Fax Number** please specify): ……………………………………………………………………..

**Postal Address**:  as above

Other (please specify)……………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………….

**Collecting in Person:** Please bring photographic identification with you. If it is to be collected by another individual please provide details below and ensure they bring identification with them.

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Address |  |

## Payment

|  |
| --- |
| **Preferred Payment Option**:  Bank Transfer (BACS) Cash Cheque.  (Payment must be received before work is completed) |

## DECLARATION

|  |  |
| --- | --- |
| I confirm that I am requesting the release of my medical records/information as specified above. | |
| Print Name |  |
| Signature |  |
| Date |  |

## *For Office Only:*

Received By…………………………………………………………………………………………………………………………

Date ……………………………………………………………………………………………………………………………………

updated 26.7.2016