Declaration of exemption

To be completed by the patient if they are exempt from prescription fees

Patient Name…….. Date Of Birth……

The patient does not pay because:

A		**is under 16 years of age**
B		**is 16, 17 or 18 and in full-time education**
C		**is 60 years of age or over**
D		**has a valid maternity exemption certificate**
E		**has a valid medical exemption certificate**
F		**has a valid prescription prepayment certificate**
G		**Has a war pension exemption certificate**
L		**is named on a current HC2 charge certificate**
H		***gets income support**
K		***gets income based jobseeker's allowance**
M		***Is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate**
S		***Has a partner who gets Pension Credit guarantee credit**

*** Name** **Date of birth** **NI number**

I am the ☐ patient ☐ patient's representative

To be completed by the Patient/patients representative

I received ……(insert number) medicine(s) from this pharmacy

Signed: …… **Date: ……..**

Was evidence of exemption seen? **Yes** ☐ **No** ☐