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 valid war pension exemption certificate**
L	☐	**is named on a current HC2 charge certificate**
H	☐	***gets income support or income related Employment + Support Allowance**
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