Declaration of exemption

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

Patient Name……………………………………………………….. ..   Date Of Birth……………………………

The patient does not pay because:

A	☐	**is 60 years of age or over or is under 16 years of age**
B	☐	**is 16, 17 or 18 and in full-time education**
D	☐	**has a valid maternity exemption certificate**
E	☐	**has a valid medical exemption certificate**
F	☐	**has a valid prescription prepayment certificate**
G	☐	**has a prescription exemption certificate issued by Ministry of Defence**
L	☐	**has a HC2 (full help) certificate**
H	☐	**entitled to Income Support or Income-related Employment and Support Allowance**
K	☐	**entitled to income based jobseeker's allowance**
M	☐	**has a Tax Credit Exemption Certificate**
S	☐	**has a Pension Credit Guarantee (including partners)**
U	☐	**entitled to Universal Credit and meets the criteria**

The information I have given is correct and complete and I confirm proper entitlement to exemption

I am the patient ☐   I am the 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 ☐