

**NATIONAL FREE CONTRACEPTION SERVICE SCHEME: REGISTERED MEDICAL PRACTITIONER DETAILS AND ACCEPTANCE FORM**

I.....(hereafter called the “Registered Medical Practitioner”) having practice premises as set out below and being a Registered Medical Practitioner entered on the Register of Medical Practitioners maintained by the Irish Medical Council in that name, practising in the State, hereby agree to deliver the Services in accordance with the terms and conditions set out in this Contract to Eligible Persons.

<b>1.</b>	<b>Registered Medical Practitioner’s Full Name</b> <i>(as it appears on the Irish Medical Council Register)</i>	<table border="1" style="width: 100%; height: 40px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																																																											
<b>2.</b>	<b>Irish Medical Council Number</b>	<table border="1" style="width: 100%; height: 30px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																																																											
<b>3.</b>	<b>Practice Premises Address</b>	<table border="1" style="width: 100%; height: 100px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																																																											
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<b>5.</b>	<b>GMS /PCERS assigned Number</b> <i>(where applicable)</i>	<table border="1" style="width: 100%; height: 30px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																																																											
<b>6.</b>	<b>Practice Telephone Number</b>																																																																												
<b>7.</b>	<b>Healthmail Email Address</b>																																																																												
<b>8.</b>	<b>Practice Email Address</b>																																																																												

The Registered Medical Practitioner agrees to notify the HSE of any changes or proposed changes in respect of any information provided in this **Registered Medical Practitioner Details and Acceptance Form** in accordance with the Notice provisions at **Clause 17** of this Contract.

By signing below, the Parties hereby agree to the above and to the terms of the Contract.

<p><b>Signed by the Registered Medical Practitioner:</b></p> <p>_____</p> <p><b>Printed Name:</b></p> <p>_____</p> <p><b>Date:</b></p> <p>_____</p>	<p><b>Signed by Authorised Representative of the HSE</b></p> <p>_____</p> <p><b>Printed Name:</b></p> <p>_____</p> <p><b>Date:</b></p> <p>_____</p>
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The HSE intends to compile a list of names and contact details of Registered Medical Practitioners who are providing this Service for patient information and service accessibility purposes.

If you would like to be included on this list please tick the box