**Greystones Health Centre,**

**Victoria Road,**

**Greystones,**

**Co. Wicklow.**

**Tel: 01 2877311**

**Fax: 01 2877343**

**Application for Chiropody Treatment**

With reference to your application for chiropody treatment, please have this form completed at parts 1 and 2

**Part 1 – Particulars to be furnished by the applicant**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Single/Married/Widowed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Card No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever held a chiropody card: \_\_\_\_\_\_\_\_\_\_\_\_ If so state number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Chiropodist you wish to attend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 2 – Particulars to be furnished by the applicants Doctor, Chiropodists or Public Health Nurse**

I certify that I have examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and in my opinion, he/she is in need of chiropody treatment.

How often does he/she require treatment in any period of two years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?

**If the number of treatments recommended in the period of two years exceeds eight (8) then a note must be submitted from your doctor stating clearly the condition necessitating extra treatments.**

Is the applicant able to travel to the Chiropodist? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If not please state the reason why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Persons under 65 years are not eligible for free Chiropody Treatment unless they hold a full valid medical card and there are definite medical indications present. A medical certificate from the applicants G.P. is required in this case. Failure to provide the relevant documentation will result in your application being delayed.**

Name: (PLEASE PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: (PLEASE CIRCLE) Doctor/Chiropodist/Public Health Nurse

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_