



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

APPLICATION FORM

LONG TERM ILLNESS SCHEME

The Long Term Illness Scheme applies only to persons suffering from any of the following diseases or disabilities: Mental Handicap; Mental illness (for persons under 16 yrs only); Phenylketonuria; Cystic Fibrosis; Spina Bifida and Hydrocephalus; Haemophilia; Cerebral Palsy; Epilepsy; Diabetes Melitus and Diabetes Insipidus; Parkinson's Disease; Acute Leukaemia; Muscular Dystrophy; Multiple Sclerosis.

PART I – To be completed by applicant:

I wish to apply for benefit under the above scheme:- (USE BLOCK CAPITALS)

SURNAME: _____ FIRSTNAME: _____

BIRTH SURNAME: _____ PHONE NO. _____

ADDRESS: _____

MOTHERS MAIDEN NAME: _____ DATE OF BIRTH: _____

PPSN NO (RSI NO): _____

DO YOU HAVE A MEDICAL CARD? YES NO MEDICAL CARD NO: _____

NAME and ADDRESS OF GP/ FAMILY DOCTOR: _____

NAME OF HOSPITAL/CONSULTANT: _____

NAME and ADDRESS OF PHARMACY: _____

SIGNATURE OF APPLICANT: _____

Or parent/guardian if aged under 16 years

PART II – To completed by applicant's doctor/consultant

I certify that _____ is under my care for the treatment of _____
(Insert medical condition) and his/her present requirements for the treatment of the conditions are as follows:

Medical Preparation	Dosage	Quantity	Doctor/Hospital Stamp

Please add additional pages as required.

Signature of Doctor/Consultant: _____ Date: _____

PART III – For official use only:

Application approved by: _____ Grade: _____

Date: _____ Authorisation Number Assigned _____