

# Medicine Delivery Sign Up Form

Here you can sign up to have your medicines delivered to your doorstep at your convenience.  
This will save you time and hassle of coming to the Pharmacy to collect your balance medicines from a valid prescription

## HOW TO SIGN UP

**Step 1: Fill in this form**

**Step 2: Take a photo of your prescription (front and back)**

**Step 3: Attach the Original Prescription**

**Step 4: Attach copy of any Medical Benefit Card/Documents**

**You are Eligible if:**

- You are a patient of SingHealth who has received consultation at our Specialist Outpatient Clinics, National Specialty Centres or Polyclinics
- You wish to receive medicines from your existing valid prescription
- You have no changes to medicine dosage

### PLEASE FILL IN

#### **Patient's Particulars:**

Name:	<input type="text"/>	NRIC:	<input type="text"/>
Contact No.: (Home)	<input type="text"/>	(Mobile)	<input type="text"/>
Email Address:	<input type="text"/>		
Delivery Address:	<input type="text"/>		
		Singapore	<input type="text"/>

#### **Requestor's Particulars** (If requestor is not patient)

Requestor's Name:	<input type="text"/>	Contact No:	<input type="text"/>
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I undertake to submit the original prescription and provide all relevant information required, including medical information and other personal data that are reasonably expedient for the purpose of fulfilment of the Medicine Delivery Service ("Required Information").

I consent to disclose all Required Information to the Relevant SingHealth institution, and all its staff, personnel or third-party service providers for the above-mentioned purpose, I also permit SingHealth to share Required Information with agents, representatives and trusted service providers and contractors for the limited purposes of fulfilling the prescription orders, communicating with patients, providing customer service, and all other reasonably related purposes.

I acknowledge, fully understand and accept all Terms and Conditions of SingHealth Pharmacy Medicine Delivery Service that have been explained to me, as set out below, I shall not hold the SingHealth Institutions responsible for any loss of documentation that has been issued to me.

I authorise the relevant SingHealth Institution(s) to charge me for all my medicine bills. If, for any reason, the credit / medical benefit card is rejected by the issuing institution, I agree to make payment upon receipt of the tax invoice.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date