Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

LHO North West Dublin
PCCC Directorate
Dublin North East Area
Rathdown Road
Dublin 7
Tel: 882 5000
Fax: 882 5168

APPLICATION FORM FOR MEDICAL AND SURGICAL SERVICES FOR MOTHERS AND INFANTS UNDER SECTIONS 62 & 63 OF THE HEALTH ACT, 1970

This form, when completed by applicant and doctor should be returned to: Maternity Services at the above address

SECTION A. TO BE COMPLETED BY THE APPLICANT *(In block letters)*

I hereby apply for Maternity and Infant Services under the Health Act, 1970.

P.P.S. No. : _____

NAME: _____ **MAIDEN NAME:** _____

DATE OF BIRTH: _____ **MEDICAL CARD NO. (if any):** _____

ADDRESS AT WHICH I NORMALLY RESIDE: _____

TELEPHONE NO: _____ _____

I apply to Doctor _____ To

(a) Accept me for medical and surgical services in respect of motherhood and

(b) Provide medical and surgical services for my infant.

I HAVE NOT MADE ARRANGEMENTS FOR THESE SERVICES WITH ANOTHER MEDICAL PRACTITIONER.

Signature of Applicant: _____ **Date:** _____

SECTION B. TO BE COMPLETED BY THE DOCTOR *(In block letters)*

I *undertake to provide medical and surgical services for* (a) the person named above and (b) the infant in accordance with the conditions laid down in the Agreement made between me and the Health Service Executive for the provision of services under Sections 62 & 63 of the Health Act, 1970.

E.D.D: _____

Confinement will take place in _____

SIGNED: _____
Medical Practitioner

ADDRESS: _____

DATE: _____

Doctor's Stamp

For Office Use P.T.O.