



EASTERN HEALTH BOARD

COMMUNITY CARE AREA 9
Poplar House
Poplar Square
Naas
Co Kildare
Telephone (045) 876001

For official use only.

Card No.

Date issued

Renewed

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Date

APPLICATION FOR CHIROPODY TREATMENT

Please complete Part 1 of this form and then bring the form to your doctor, who will complete Part 2 of the form if Chiropody treatment is necessary.

PART 1 PARTICULARS TO BE FURNISHED BY APPLICANT

Name _____ Date of Birth _____

Address _____

Medical Card Number _____ Review date of Medical Card _____

Married/Single/Widow/Widower _____

Name and Address of Chiropodist you wish to attend _____

Do you hold, or have you previously held an Eastern Health Board Chiropody Card? _____

If YES, please state -

(a) Expiry date of Chiropody Card _____ (b) Reg. No. of Chiropody Card _____

*NOTE: Persons requiring treatment will be referred only to Chiropodists on the panel.
A list of Chiropodists on the panel may be had from this department on request.*

PART 2 PARTICULARS TO BE FURNISHED BY THE DOCTOR OR PUBLIC HEALTH NURSE

(* Strike out whichever does not apply)

I certify that I have examined _____

*He/She IS/IS NOT in need of chiropody treatment.

* He/She is suffering from _____

and is in need of Chiropody treatment.

Is the applicant able to travel to a Chiropodist? _____

If not, please state reason why _____

Signature of Doctor or Public Health Nurse: _____

Address _____

Date _____