

Surgery Free Standing Pre-Installation Questionnaire

Section A: Practice Details *(Please complete in block capitals)*

Practice Name:	
Address 1:	
Town:	
County:	
Postcode:	
Telephone Number:	
Fax Number:	

Section B: Contact Details *(Only used with regards to rack)*

Contact Name:	
Position:	
Email address:	
Tel No:	

Section C: Surgery Details

In the boxes provided please enter the number of the following in your surgery.

Doctors: Nurses: Nurse prescribers:

What clinics are currently run in your surgery and what quantities of patients

subscribe to these? *(Please tick as appropriate and write the quantity below each clinic type.)*

Allergy: Diabetes: Travel Clinic:

Anti-Smoking: Nutrition & Diet: Vaccination:

Asthma: Heart Health:** Well Man:

Baby Clinic:* STD: Well Woman:

* Includes Ante-Natal, Child Health/Illness, Family Planning and Maternity.

** Includes Blood Pressure.

How Many Registered Patients do you have? _____

Is There a particular demographic lending (Age) ? *(Please tick as appropriate.)*

18-29 30-39 40-49 50-59 60+

What are your surgery access hours? *(Please enter the times we can gain access to the site)*

Open AM:	<input type="text"/>	Close AM:	<input type="text"/>
Open PM:	<input type="text"/>	Close PM:	<input type="text"/>

Half Days / Regular Closures
(Please state days and times)

<input type="text"/>

What parking facilities would be available to our field staff? *(Please tick as appropriate)*

Surgery Car Park: Off Road Parking: Metered Parking:
Roadside Spaces: No Parking:

In the space below please details availability of spaces and distance to the surgery:

Section D: Rack Location

Where would you like the rack to be installed? *(Please tick as appropriate)*

Please note that the rack cannot be installed in treatment rooms.

Please check that there is appropriated wall space is available (H107 x W76 x D11cms)

Waiting Room: Reception: Foyer:

Section F: Health & Safety

When visiting your surgery would our staff be entering a dangerous area where they may have to take precautionary measures? *(Please tick as appropriate)*

Yes No

Section E: Other

Please provide further information that may be relevant in the space provided, if necessary attach information using a separate sheet.

Section F: Service Agreement

Please find attached a service agreement and that we ask you to complete and return with your completed questionnaire.

Please read the service agreement carefully, as once completed you are agreeing to make payment of £200 to Waiting Room Information Services should the free standing rack be lost, or disposed of without prior permission. By asking you to cover the manufacturing costs of missing racks it ensures that we are able to continue operating this service on a free of charge basis.

Please be assured that we will not be asking for any kind of payment for any normal wear and tear, rack maintenance, or leaflet supply.

Once you have been accepted to receive the service, the leaflet display rack will be delivered to your surgery. Following this delivery a key installer will visit your surgery to assemble the rack and determine effective and safe positioning. On signing the enclosed agreement you will also agree not to move the rack from this position without prior authorisation from our office; and that Waiting Room Information Services cannot be held responsible for any damage/injury caused by the misuse of the rack.

**Free Standing Patient Leaflet Rack Service
Service Agreement**

Site Address:

£200.00 will be payable by the above site on loss or disposal of the free standing leaflet display rack, unless former authorisation has been given by the Waiting Room Information Services Head office.

The free standing rack will not be moved from the agreed position, unless former authorisation has been given by Waiting Room Information Services head office.

Waiting Room Information Services cannot be held responsible for any damage/injury caused by misuse of the free standing leaflet display rack.

I have read and accept the terms and conditions detailed above.

Signed:

Date:

Name:

(Please print in Block Capitals)

Title:

(Please print in Block Capitals)

If you require additional questionnaires, or have any queries please contact W.I.S on 01489 860000.