

FIREARMS MEDICAL REPORT INFORMATION FORM

This is a remote service, a face to face appointment is not required, the service is available nationwide. We will require some basic information, personal and medical, in order to successfully process your application

Please specify

Is this a renewal ?

Is this an initial grant?

Application Reference from Police (if known): _____

Personal Details:

Name:	
Date of Birth:	
House name/no.	
Street:	
Town/City:	
Post Code:	
Contact No:	
Email:	

General Practice Details:

Name of GP:	
Name of Surgery:	
Street:	
Town/City:	
Post Code:	
Telephone No.:	
Email:	

Firearms Officer (if known)

Firearms Officer Name	
Firearms Licensing Police Force	
Firearms Officer Contact:	
Firearms Office Email:	

Have you declared any conditions on your
firearms/shotgun license application/renewal form?

YES / NO

Consent for Shooting Medicals to carry out our full medical reporting process

I consent to Shooting Medicals Ltd requesting my medical records from my GP and holding and reviewing my full medical records as part of my firearms/shotgun application or renewal. I also consent to any relevant medical conditions being disclosed on my medical report verification and subsequently reported to the police. I consent to my report being sent directly to the firearms licensing officer (in cases where the police accept this) or back to me by email/post in cases where the police require the report to be sent back to me. As per 2019 Home Office statutory guidance I consent to Shooting Medicals writing to my GP surgery to request that my NHS GP adds a marker to my patient record (if such a marker is not already present on my patient record) to enable the NHS GP to flag up to police any new medical issues which emerge following the grant of the certificate.

I consent (please tick) ☐

Consent to report being sent to the police by non NHS email

I give consent to Shooting Medicals to send the report directly to the relevant police forces via a non NHS email. Police guidance states that they cannot be held responsible for any loss or inappropriate access to emails sent to them from a non NHS email address. If you do not give consent we will send the report by recorded post only. For force areas that request that your medical report is sent back to you we will email you or post the report if you prefer.

I consent (please tick) ☐

Declaration	
Print name:	
Signed:	

Please return the completed form to Shooting Medicals
via email **firearmmedical@shootingmedicals.com**