

Chronic Courier Pharmacy

Delivery amendment form



Kindly indicate your amended requirements and fax or email your completed form to **0861 00 4367** or **chronicDSP@gems.gov.za** respectively. Please note that the completion of Section A is compulsory.

Section A: Membership details (Main member)

Surname First full name
Date of birth or ID no Membership no

Section B: Delivery details

Please tick the appropriate block and provide details of amendments in the space provided.

New delivery address for your medicine

Temporary delivery address for your medicine

Period of stay at temporary delivery address _____

Person to receive or collect medicine

Contact details
Physical address
 Code
Postal address
Tel no (H) () Tel no (W) ()
Cell phone no Fax no ()
Email

Delivery schedule

Re-schedule next delivery date to

Medicine delivery

Exclude the following medicine in the next scheduled delivery date and resume sending thereafter:

Exclude the following medicine in the next scheduled delivery date and only resume sending upon request:

Resume sending the following medicine:

Permanently stop the delivery of the following medicine:

Another request not mentioned above:

Signature of main member _____ Date