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|--|---------------------------|-------------------------------|
| APPLICANT (stamp or sticker acceptable) | PATIENT NHI: | REFERRER Reg No: |
| Reg No: | First Names: | First Names: |
| Name: | Surname: | Surname: |
| Address: | DOB: | Address: |
| | Address: | |
| | | |
| Fax Number: | | Fax Number: |

Tetracycline

Initial application

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

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|--|
| <input type="checkbox"/> For the eradication of helicobacter pylori following unsuccessful treatment with appropriate first-line therapy |
| and |
| <input type="checkbox"/> For use only in combination with bismuth as part of a quadruple therapy regimen |

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz