|  |  |  |
| --- | --- | --- |
| Date: | Time:  (To be filled in at time of test) | URN:  (To be filled in at time of test) |
| First Name |  | |
| Last Name |  | |
| DOB |  | |
| Email |  | |
| Mobile Number |  | |
| First Line of address  and Postcode |  | |
| Ethnicity |  | |
| Name and unit of the person you are visiting |  | |

**By completing this form you are consenting for a Lateral Flow test to be completed and your details used to register it.**