

## PART 5 - TO CONFIRM THE AUTHORITY OF RESPONDENT(S)

How long have you known the person in respect of whom you have completed this form?

2 years 6 months

Name of Clinician

Prof. Brown

Department

Gastroenterology

Hospital

Gloucestershire Royal Hospital

Address

Great Western Road

Gloucester

Post Code

GL1 3NN

Signature of Clinician

GRO-C

Hospital Stamp

Clinician's  
GMC number

GLoucestershire HOSPITALS NHS

TRUST

GLoucestershire ROYAL HOSPITAL

GT WESTERN ROAD

GLoucester GL1 3NN

How long have you known the person in respect of whom you have completed this form?

years months

Name of Clinician

Department

Hospital

Address

Post Code

Signature of Clinician

Hospital Stamp

Clinician's  
GMC number

How long have you known the person in respect of whom you have completed this form?

years months

Name of Clinician

Department

Hospital

Address

Post Code

Signature of Clinician

Hospital Stamp

Clinician's  
GMC number

How long have you known the person in respect of whom you have completed this form?

years months

Name of GP (if relevant)

Surgery

Address

Post Code

Signature of GP

Surgery Stamp &  
GMC number

Please return the completed form to the Skipton Fund in the freepost envelope supplied

Thank you very much for your help in completing this form