Patient Participation Group Application Form

If you are happy for us to contact you occasionally by email, please fill in the form below and hand it in at reception.

Title (Mr/Mrs/Ms):	Name:	
Email:	Telephone:	
Address:		
	Postcode:	Usual Surgery:
The following information he mix of patients registered wit		en from a group of patients which represents the
Gender: □Male □Fem	ale	
Age Group: □ Under 16 □ 25 - 34 □ 45 - 54 □ 65 - 74 □ Over 84	□ 17 - 24 □ 35 - 44 □ 55 - 64 □ 75 - 84	
Ethnic Origin: I would descr	ibe my ethnic origin as follows	: (please tick as appropriate)
White □ British □ Irish □ Other Black Background	Mixed ☐ White & Asian ☐ White & Black African ☐ White & Black Caribbean	Other □ Chinese □ Other Ethnic Group
Black or Black British ☐ African ☐ Caribbean ☐ Other Black Background	Asian or Asian British ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Other Asian Background	☐ I do not wish to disclose
How would you describe ho	w often you come to the Practi	ice?
☐ Regularly ☐ Occas	sionally	
To get us started - Ideas/Sug	gestions/Comments	

The information you supply us will be used lawfully, in accordance with the Data Protection Act 1998. The Data Protection Act 1998 gives you the right to know what information is held about you and sets out rules to make sure that this information is handled properly.