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 helps us to ensure feedback is taken from a group of patients which represents the mix of patients registered with the practice.

Gender: ☐ Male ☐ Female

Age Group:
☐ Under 16
☐ 17 - 24
☐ 25 - 34
☐ 35 - 44
☐ 45 - 54
☐ 55 - 64
☐ 65 - 74
☐ 75 - 84
☐ Over 84

Ethnic Origin: I would describe 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 how often you come to the Practice?

☐ Regularly ☐ Occasionally ☐ Very Rarely

To get us started - Ideas/Suggestions/Comments

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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.