HAWTHORN MEDICAL PRACTICE

PATIENT PARTICIPATION GROUP

If you are happy to be part of the Hawthorn Medical Practice Patient Participation Group (PPG), please complete this form and return it to the practice, either via post, in person or email to licb.ppg.hawthornmp@nhs.net

NAME:……

ADDRESS:……

…… **Post Code**:……..

CONTACT TELEPHONE NUMBER:……

EMAIL ADDRESS:……..……

AGE: Please tick as appropriate

	16 - 25		**26 - 35**		**36 - 45**
	46 - 55		**56 - 65**		**0ver 66**

Which ethnic background do you represent? Please tick as appropriate

	White British		**British or Mixed British**		**Irish**
	Other White Background		**Caribbean**		**White & Black Caribbean**
	African		**White & Black African**		**Other Black Background**
	Other Mixed Background		**Indian or British Indian**		**Pakistani or British Pakistani**
	Bangladeshi or British Bangladeshi		**Other Asian Background**		**Chinese**
Other (Please state)					
	I have no wish to state my ethnicity				

How do you prefer to be contacted? Please tick as appropriate

	Telephone		**Post**
	Email		**No Preference**

How would you like to be involved in Hawthorn Medical Practice PPG? Please tick as appropriate

	Active Members – attends meetings etc
	Virtual Member

Which of the following areas would you like us to focus on? Please tick all that apply

	Getting an appointment		**Clinical Care**
	Telephone answering & access		**Waiting Room Facilities**
	Customer Service		**Time Keeping**
	Patient Information		**Opening Times**
Other (Please specify)			

Consent

I…… grant permission for my contact details to be passed to a fellow member of Hawthorn Medical Practice Patient Participation Group (PPG) for the sole purpose of PPG matters.

Signed……Date……

Print……

Hawthorn Medical Practice will NOT release PPG members details to any unauthorised third party