Become a member of our Patient Participation Group

Title (please circle)

Mrs Miss Ms Mr

First Name

Surname

Date of Birth

Email Address

Telephone

The following information is optional but is requested so that we can ensure our patient group represents the wide variety of patients we have at the surgery. It will remain confidential and the information provided will not impact your application to join.

Gender (please circle)

Male Female

Do you consider yourself to have a disability? (please write below)

What ethnic background do you closely identify with? (please write below)

How would you describe how often you come to the practice? (please circle)

Regularly

Occasionally

Very rarely

Please return this form to our reception or email us at: nclicb.patients.speedwell@nhs.net
A member of the team will be in touch shortly!