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**Patient Participation Group**

*Expression of Interest*

As a Practice we are keen to set up a Patient Participation Group, and we would like to invite you to become a member. We would like to hear your views on what works, what doesn’t and what improvements you would like to see within your Practice.

We are looking to involve as many patients in the group as possible, on a voluntary basis so that we can shape and develop the services that we deliver to you. We are starting by looking for willing volunteers that are happy to be contacted periodically to get their views and maybe attend an occasional meeting.

If you are interested, please let us have your details.

|  |  |
| --- | --- |
| NAME |  |
| ADDRESS |  |
| TELEPHONE NUMBERMOBILE NUMBER |  |
| EMAIL ADDRESS |  |

To help ensure our contact list is representative of our local community, please provide the following information. Your answers will be treated in the strictest of confidence.

|  |  |
| --- | --- |
| Date of Birth |  |
| Sex |  |
| Which ethnic group do you belong to? (Please tick)  | WhiteMixedAsian/Asian BlackBlack / Black BritishChineseOther ethnic group |
| Do you have any longstanding illness, disability, or infirmity? (Please tick)  | YesNo |
| If yes, does this limit your activities in any way (please tick) | YesNo |
| How often do you come to the Practice? (Please tick) | RegularlyOccasionallyVery Rarely |

**How would you like to be involved?**

Virtually (via email and internet)

Physically (attend occasional meetings where required)

Actively (support activity in the Practice, e.g., help patient’s complete surveys in the practice)

Thank you for your interest

**PLEASE RETURN THIS FORM TO THE SURGERY MARKED “PATIENT PARTICIPATION GROUP”**

*Please note that no medical information or questions will be responded to. The information that you supply us will be used lawfully, in accordance with the Data Protection Act 1998*