**Patient Participation Group Enquiry/ Application Form**

|  |  |  |
| --- | --- | --- |
| Name | Address | Contact details |
|  |  | Tel:Email: |

We would like to make sure our patient group represents the range of patients in our practice. It would help if you would answer the questions below which are designed to do this. Just leave any blank if you do not wish to answer these.

Delete or ring as appropriate

|  |  |
| --- | --- |
| Gender | Male / Female  |
| Marital Status  | Married / Single / Divorced / Widowed |
| Age | Under 1617-2425-3435-44 | 45-5455-6465-74Over 74 |
| Ethnic Origin | White BritishWhite IrishOther White BackgroundIndianPakistaniBangladeshiChineseOther Asian Background | Mixed White and Black CaribbeanMixed White and Black AfricanWhite and AsianOther Mixed BackgroundCaribbeanAfricanOther Black BackgroundOtherNot given |
| Do you consider yourself to have a disability?  | YES / NOIf Yes, please provide brief information: |

**Thank you for expressing your interest. All applications/ enquiries will be acknowledged and you will hear from us again soon.**