**Patient Participation Group**

🞎 I wish to join the Patient Participation Group

🞎 I wish to join the Virtual Patient Group

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS (If you wish to be contacted and do not have an e-mail address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The details provided above will be passed on to the Chair of the Patient Participation Group.

E-mails will be distributed to patient members as a group. If you do not wish for others to see your e-mail address please tick here🞎. Please note that by ticking this box, you may be excluded from replies to group e-mails.

If you do not wish for your name to be included in the minutes of meetings, please let the Secretary know when you attend the meeting.

To try and make sure we speak to a representative sample of the patients that are registered at Leek Health Centre, we would be grateful if you could answer the following question:

Which ethnic background do you most closely identify with?

White British 🞎 Irish 🞎

White & Black African 🞎 White & Black Asian 🞎

White & Black Caribbean 🞎 Indian 🞎

Pakistani 🞎 Bangladeshi 🞎

Caribbean 🞎 African 🞎

Chinese 🞎 Other 🞎

**Confidentiality Agreement**

During the course of your association with Leek Health Centre regarding PPG matters, you may have access to, see or hear, confidential information concerning the practice which must not be disclosed to any other person. Confidential information includes all information relating to the Practice and its patients and employees. In the capacity as PPG members this information would be limited.

This condition applies during your relationship with the Practice and after the relationship ceases.

I understand that I am bound by a duty of confidentiality and have read, understood and agreed to the Practice’s Confidentiality Agreement.

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_