



Thank you for your interest in our Virtual Participation group. Please provide us with your contact details and we will be in touch.



Title (Mr, Mrs, Ms, Dr etc)	
Full Name:	
Home Address	
Telephone Numbers	Day time telephone number: Evening telephone number: Mobile telephone number:
Email Address	

I would be interested in joining the Virtual Patient Participation Group ☐
I would be interested in attending a group meeting occasionally ☐
Are there any particular issues / areas of healthcare that might be of interest to you?
Or do you have any relevant experience that would be beneficial to the group?
Please sign to given us consent to use your details for the purposes of Patient participation group communications Signature Date
Please note the information collected on this form will only be used for the purposes of the Patient Participation Group and will not be disclosed to any internal or external sources not involved in this group without your prior agreement.
Please complete this form and return to: Suzanne Molloy Practice Manager Wallasey Medical Centre 1 Wallasey Crescent Ickenham Middlesex UB10 8SA