WHITSTABLE
MEDICAL PRACTICE
PATIENT PARTICIPATION GROUP

Whitstable Medical Practice
Patient Participation Group

Membership Application Form

Name …….. Mr / Mrs / Ms / Miss ……..

Address ……..

…….. Post Code: ……

E-mail* …….. Telephone* ……..

* I consent to these contact details being shared with WMP PPG members ……

I am a registered as a patient at: Whitstable Health Centre ……
(Please tick as appropriate) Chestfield Medical Centre ……
Estuary View Medical Centre ……

Signed …… Date: ……

Do you have experience of any areas of health issues which you feel would be of benefit to the WMP Patient Participation Group?

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Are you a member or supporter of any other health or social care groups or organisations?

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……

Please tick as appropriate: -

Are you interested in becoming a PPG Committee Member? ……..
(This will entail regular attendance at Committee meetings)

or

Do you want to be kept informed of developments at WMP as a Virtual PPG member? ……

To help monitor that the group is representative of a cross section of patients it would be appreciated if you could kindly indicate the following:

Age group (yrs) 16 to 25 ……. 25 to 40 ……. 40 to 65 ……. over 65 …….

Are you a parent of a child? Under 5 yrs……. 5-12 yrs ……. 12-18 yrs …….

Do you look after a relative or close friend as a Carer? Yes / No

Please return this form to:

Patient Participation Group, Estuary View Medical Centre, Boorman Way, Whitstable, CT5 3SE.
Or e-mail to: info.wmp@nhs.net

June 2019