**PATIENT PARTICIPATION GROUP MEMBERSHIP FORM**

|  |  |  |
| --- | --- | --- |
| **RESERVOIR ROAD PATIENT PARTICIPATION GROUP** | | |
| **Would you like to become a member of our Patient Participation Group?**  **This is a group of patients who meet once every three months and discuss a wide variety of topics that relate to the practice (see the Minutes of the previous meetings on the website)**  **If you think that you could bring something to the table within these meetings why not apply and come along to the next meeting.**  **Please complete this form and hand at the reception desk and the practice manager will contact you.** | | |
| **NAME** | **D.O.B** | **EMAIL ADDRESS** |
|  |  |  |
| As part of the Membership Group I understand that my name will appear on minutes and be available to patients and the public.  **Confidentiality statement:**  During the course of your membership of the Patient Participation Group activities within the practice you may hear or see information about staff, patients or other matters.  The disclosure of this information to anyone is considered to be serious misconduct and could contravene the Data Protection Act 2018  Unauthorised disclosure of confidential information is a serious matter for you, the patients and the practice and could lead to legal action to all parties involved.  I have read and understood the confidentiality statement above.  Signed: …………………………………………………………………. Date: ………………………………………….. | | |