PATIENT PARTICIPATION GROUP CONSENT FORM

Would you like to become a member of Skegby Family Medical Centres Patient Participation Group? Yes ☐ No ☐ If yes, will you be attending the meetings in person or virtually? Meeting ☐ Virtual ☐
Please print your full name in capital letters on the line provided below. ----------
Please sign on the line provided below. ----------
Would you like to receive information and updates regarding the patient participation group via email? Yes ☐ No ☐ If yes, please confirm your current email address below. ----------

Please return this form to Skegby Family Medical Centre once filled out at your earliest convenience.

We look forward to hearing from you.