# BEECHWOOD MEDICAL PRACTICE

## Patient Participation Group

I would like to register my interest in joining the patient participation group.

Name ........................................................................................

Address......................................................................................

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Contact Telephone Number................................................

Email Address.............................................................................

To allow us to measure the levels of representation across our patient population, it would help us if you could also please let us have details of the following:

Age ………… ............Male or Female………………………

Ethnicity……………………………………………………

Please return completed forms to reception or the practice address:
Beechwood Medical Practice, Beechwood Road, Fishponds, Bristol BS16 3TD
Or email to beechwoodmedicalpractice@nhs.net (Please do not use this email address for personal patient enquiries)