

MEDICAL STUDENTS

MOSS GROVE SURGERY - PATIENTS HELPING MEDICAL STUDENTS

Please tick the appropriate box

I WOULD BE WILLING TO TALK TO A MEDICAL STUDENT ABOUT _____ _____ (NAME OF ILLNESS / MEDICAL PROBLEM)	<input type="checkbox"/>
N.B. any details you may give are treated with the same confidentiality as your medical records	<input type="checkbox"/>

I WOULD BE WILLING TO LET A MEDICAL STUDENT PRACTISE THEIR CLINICAL SKILLS UNDER THE SUPERVISION OF A DOCTOR.	<input type="checkbox"/>
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NAME:	DATE OF BIRTH:
Address:	
Telephone:	

PLEASE HAND COMPLETED FORM TO RECEPTION