For Office Use Only:
Date Received: Contact Date: _____ Interview Date:_____

Patient and Family Advisor Application Form

Name: Date of Birth:		Home Phone:
Address:		Cell Phone:
City/Town and Province:	Postal Code:	Email:

I have been: ❑ A patient ❑ A family member/caregiver
I am interested in: ❑ Patient Family Advisory ❑ Mental Health Youth Advisory

My care/my family member's care provided at BCHS was primarily (check all that apply):

❑ Hospitalization (Inpatient) ❑ Emergency Department visit
❑ Clinic visit (Outpatient services) ❑ Other programs, departments or services

Why do you want to become a Patient Family Advisor?

There are many ways to participate as a Patient Family Advisor. Please check the area(s) that interest you:

❑ Participate in different working groups/committees/planning sessions
❑ Become a member on one of our Program Councils (Mental Health, Surgery, Medical, Cardiac, ED etc.)
❑ Become a member on the CEO Patient Family Advisory Council (application process involved)
❑ Share your story with health care providers, staff or Board members
❑ Participate in Short term projects (on an as need basis)
❑ Participate in Board governance committees (an additional screening process will be necessary)
❑ Other Special interests: _____

Please choose the days and times when you are available to volunteer – Check all that apply:

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday
❑Morning ❑ Afternoon

❑ Virtual/phone
❑ In Person

Brant Community Healthcare System's top priority is ensuring everyone's safety. BCHS is responsible for protecting patients, visitor and employees from disease and infection which may be brought into the hospital by new volunteers. For this reason and as a condition of volunteer placement, all new volunteers must receive a passing health review required by the system in accordance with the Public Hospitals Act and other legislation. Repeat examinations as required by legislation or the hospital are mandatory.

WILL YOU AGREE TO UNDERGO A HEALTH REVIEW? Yes ❑ No ❑

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE FOR WHICH A PARDON HAS NOT BEEN GRANTED? Yes ❑ No ❑

I hereby authorize Brant Community Healthcare System to contact any of my references to make inquiries necessary to determine my suitability for this volunteer position.

I acknowledge that all information listed here is true to the best of my knowledge. I understand that, if and when I discontinue my role as a volunteer with Brant Community Healthcare System, I must return my identification badge.

Signature: _____ Date: _____

Please return this application form to:

Patient and Client Experience Leader
Brant Community Healthcare System
200 Terrace Hill Street
Brantford, ON N3R 1G9

If you have questions please contact:
Patient Relations at (519) 751-5544 Ext. 2395 or patientrelations@bchsys.org

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: _____
Phone:_____
Relationship:_____

Personal information provided in this form is collected for operational and organizational purposes and held in strict confidence. This information will be used to determine compatibility of needs and interests of the volunteer with those of BCHS. Telephone numbers and e-mail addresses provided by volunteers may be shared with BCHS staff for the specific purpose of contact volunteers.