Application for Patient and Family Advisor

Title: Miss Mrs. Ms. Mr. Dr. **Name:**		**Home Phone:**
Address:		**Cell Phone:**
City:	**Postal Code:**	**Email:**

It is the responsibility of the Brant Community Healthcare System to protect its patients and staff from any disease or infection, which might be brought in by new volunteers. For this reason all new volunteers must, as a condition of volunteer placement, receive a passing health review as required by the System, in accordance with the Public Hospitals Act and other legislative Acts. Repeat examinations as required by legislation or the hospital are mandatory.

Would you consent to a health review?

☐ Yes ☐ No

I am:

☐ A patient (within the past 2 years) ☐ A family member of a patient

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

☐ Hospitalization (inpatient)
☐ Emergency department visit
☐ Clinic visit (outpatient services)
☐ Other programs, departments or services

Have you ever been convicted of a criminal offence for which a pardon has not been granted?

☐ Yes ☐ No

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

☐ Committee work (i.e., Patient Advisory Council, Quality Council, etc. – monthly meetings to bring patient/family perspective)
☐ Ad hoc working groups (shorter term in duration)
☐ Focus group or strategic planning sessions
☐ Story sharing – with other patients and/or healthcare providers
☐ Short term projects (become a partner in making improvements to specific healthcare services)
☐ Board governance committees (an additional screening process will be necessary)
☐ Other special interests: _____

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Please list times when you are available to volunteer (please check all that apply):

☐ Daytime ☐ Evening ☐ Weekend

I hereby authorize the Brant Community Healthcare System to contact any of my references to make any inquiries required in determining my suitability of 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 the Brant Community Healthcare System that I must return my I.D. Badge.

Signature: _____ Date: _____

Please return this completed application form to:

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

If you have any questions please contact:

Patient Experience/Patient Relations at 519-751-5544, ext. 2395 or patientrelations@bchsys.org

In case of emergency, please notify:

Name: _____

Phone: _____

Relationship: _____

Personal information completed on this form is collected for operational and organizational purposes and is held in strict confidence. This information will be used to determine compatibility of needs and interest of volunteer with the needs and interests of the BCHS. Volunteer phone numbers and e-mail addresses may be given to BCHS staff to be used specifically to contact volunteers.

For office use only:

Date Received: _____

Contact Date: _____

Interview Date: _____