CAMPBELLFORD MEMORIAL HOSPITAL

Patient and Family Advisory Council Application Form

Name: _____

Contact Information:

Address			
City:		Postal Code:	
Telephone:		Cellphone:	
Email:			

In the past 3 years have you or your family used the services of Campbellford Memorial Hospital?

☐ Yes ☐ No

Are you a:

☐ Patient (within past 3 years) ☐ Family Member of a Patient (within past 3 years)

The care provided at CMH was primarily as: (Check all the apply)

☐ An Admitted Patient
☐ Emergency Department Patient
☐ Clinic / Outpatient
☐ Diagnostics
☐ Day Surgery Patient
☐ Other: _____

Would you be comfortable sharing your experience with the Council and/or your assigned project group/committee in order to make improvements?

☐ Yes ☐ No

Why would you like to serve as a CMH Patient and Family Advisory Council member?

What are some issues of special interest to you?

If you are applying for a specific opportunity on the Patient and Family Advisory Council, tell us a bit about how your experience/interests could be helpful to enhance our work in that area?

Please specify the time when you are able to attend meetings:

☐ Daytime between _____ and _____

☐ Evenings between _____ and _____

Are you currently a volunteer at CMH?

☐ Yes ☐ No

Please confirm that you understand each of the following:

☐ I understand that submitting this application and/or being interviewed does not guarantee a position as a CMH Patient and Family Advisor.

☐ I understand that, prior to beginning as an advisor, I would be required to submit the results of a criminal reference check (CRC) with the vulnerable sector search (18+ years old) and sign a CMH Confidentiality Agreement.

☐ I understand that, as an advisor, I would be accountable to CMH and the Patient and Family Advisory Council.

I declare the above information to be true and complete to the best of my knowledge. I understand that a false statement may disqualify me or lead to my dismissal.

SIGNATURE:_____ **DATE:** _____

☐ Please "✓" if you would like to speak with an existing Patient and Family Advisory Council member

Thank you again for your interest in becoming a CMH Patient and Advisory Council member and for taking the time to complete this application. We will confirm receipt and be in touch shortly should you be selected for an interview.