**All information is confidential. Please print.**

**Have you previously worked for Geraldton District Hospital? □ Yes □ No**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_

Contact Numbers – Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you interested in being a Patient and Family Advisor volunteer?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe any skills, experience or training that you feel may be an asset to becoming a Patient and Family Advisor?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I am a: □ Patient □ Family member of a patient □ Care partner

**Please indicate the ways in which you would like to participate as a Patient/Family Advisor.**

**Patient/Family Advisor:**

\_\_\_Participate on Committees: Bring the patient/family voice/experience to committees.

\_\_\_Story Sharing: Share your health care experience with providers and other patients.

\_\_\_Be a member of the Patient Family Centered Care Committee.

**See reverse side**

Please indicate times that you would be available for meetings.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **MON** | **TUE** | **WED** | **THUR** | **FRI** | **SAT** | **SUN** |
| **Morning** |  |  |  |  |  |  |  |
| **Afternoon** |  |  |  |  |  |  |  |
| **Evening** |  |  |  |  |  |  |  |

Do you require accommodations due to a disability that we need to know about? **□ Yes**  **□ No**

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of an emergency, the person below may be contacted:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_

Have you been convicted of an offence under the Criminal Records Act? □ Yes □ No

**I hereby certify that all information included in this application is true and complete.**

Applicant’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return this reference by mail, email or in person to:**

Kelsey Cleaveley, Co-Chief Nursing Executive

Geraldton District Hospital

PO Bag 4

500 Hogarth Ave. West

Geraldton, ON P0T 1M0

**Fax:** (807) 854-3002

**Email:** kcleaveley@geraldtondh.com

Thank you very much for your cooperation and assistance.

All information provided is confidential