 ***Patient Family Advisor Application Form***

**ALL INFORMATION IS CONFIDENTIAL Please print**

Have you previously worked for TBRHSC? ❑ Yes ❑ No

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

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

Contact Numbers: Home: Work: Cell:

Email: May we communicate with you using email? ❑ Yes ❑ No

Date of Birth

How did you hear about the Patient Family Advisor program?

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Why are you interested in volunteering your time as a Patient Family Advisor?

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Describe any skills; experience or training that you feel is an asset to becoming a Patient Family Advisor.

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I am a:

❑ Patient ❑ Family member of a patient ❑ Essential Care Partner/Care Partner ❑ Friend of a patient

What services have you or your family members used? (Check all that apply)

* Cancer ❑ Emergency ❑ Intensive Care
* Renal ❑ Medical ❑ Surgical
* Paediatrics ❑ Neurology ❑ Mental Health
* Maternal Newborn ❑ Neonatal Intensive Care ❑ Ambulatory Care
* Surgical Day Care ❑ Other

I am most interested in working in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Continue on Reverse Side 1***

Please indicate when you would be available for meetings: 🞎 Afternoon 🞎 Evening

 Do you have any physical limitations or special needs we should know about? 🞎 Yes 🞎 No

If yes, please list

Do you have any dietary preferences or allergies? 🞏 Yes 🞏 No

If yes, please list

**REFERENCES:** Please provide two references that we can contact

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:

Address:

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:

Address:

 **IN CASE OF 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 COMPLETED APPLICATION FORM TO:**

 **Shannon Schiffer**: Manager – Patient & Family Centred Care, Patient Experience, Engagement & Advocacy

Thunder Bay Regional Health Sciences Centre, Room 3020

980 Oliver Road, Thunder Bay ON, P7B 6V4

Telephone: 807-684-6345

Email: Shannon.schiffer@tbh.net