Patient Family Advisor Application

Personal Information

Application date *(DD/MM/YY):* ___ / ___ / ___

Last name: _____ First Name: _____

Street address: _____

City: _____ Postal code: _____ Phone number: _____

Date of birth *(DD/MM/YY):* ___ / ___ / ___ Email address: _____

Patient Experience Information

Advisor status: ☐ I am a patient ☐ I am a family member of a patient

My experience at Scarborough Health Network was primarily at (check all sites that apply):

☐ Birchmount ☐ General ☐ Centenary

My care provided at Scarborough Health Network was primarily (check all that apply):

☐ Hospitalization (inpatient) ☐ Emergency department ☐ Clinic visit (outpatient) ☐ Other: _____

The dates of my active care experience in the past three years at the Scarborough Health Network include:

_____

Patient Family Advisor Information

Please briefly share with us why you would like to be a Patient Family Advisor:

_____

_____

_____

_____

_____

I would be interested in helping with (check all that apply):

☐ Reviewing patient education materials ☐ Sharing my story with staff and students ☐ Short-term projects

☐ Quality improvement committee work ☐ New employee orientation ☐ Patient Advisory Council

☐ Participating in facility design and improvement ☐ Other: _____

How much time are you able to commit as a Patient Family Advisor? _____

Languages spoken: _____

Please give some of specific examples of what a health-care professional at Scarborough Health Network did or said that were most helpful to you and/or your family?

_____

_____

_____

Please give some of specific examples of what you would like health-care professionals to do differently in order to be more helpful?

_____

_____

_____

Conditions of Acceptance

I understand upon acceptance as a Patient Family Advisor, I will be required to:

- Complete volunteer registration
- Attend orientation
- Submit a current criminal record check
- Submit the results of a two-step tuberculosis (TB) test

☐ I acknowledge I have read and understood the conditions for acceptance. Date (*DD/MM/YY*): ___ / ___ / ___

Note: Box must be checked for application to be processed.

Please attach this completed form to an email and send to **pfcc@SHN.ca**. If you have any questions, please contact our Office of Patient and Family Centred Care at 416-284-8131 ext. 4938.

Through sharing your story and perspective, you will have an opportunity to make a difference in the quality of the patient experience at Scarborough Health Network.

Thank you for your application.