

Patient Family and 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/caregiver 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 at Scarborough Health Network include:

Patient and Family Advisor Information

Please briefly share with us why you would like to be a Patient and 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/Long-Term Projects
- Quality improvement committee work New employee orientation Patient and Family Advisory Council
- Participating in facility design and improvement Other: _____

How much time are you able to commit as a Patient and Family Advisor (minimum 2 hrs/month)? _____

Languages spoken: _____

Please give some of specific examples of what a healthcare 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 healthcare professionals to do differently in order to be more helpful?

Conditions of Acceptance

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

- Complete volunteer registration
- Attend orientation
- Submit a current criminal record check
- Submit health screening form, which includes 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 patientengagement@SHN.ca. If you have any questions, please contact our Office of Patient and Community Engagement at 416-238-2911 ext. 3359.

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.