Brant Community Healthcare System
The Willett, Paris
The Brantford General

For Office Use Only:

Date Received:
Contact Date: _____
Interview Date:_____

APPLICATION FOR PATIENT AND FAMILY ADVISOR

Name: Miss Mrs. Ms. Mr.		Home Phone:
Address:		Cell Phone:
City/Town and Province:	Postal Code:	Email:

I have been: ❑ A patient ❑ A family member of a patient

My care/my family member's care provided at the BCHS was primarily (check all that apply)

❑ Hospitalization (inpatient)
❑ Clinic visit (outpatient services)
❑ Emergency Department Visit
❑ Other programs, departments or services

Why have you applied to be a Patient Family Advisor?

There are many ways to participate as a Patient and Family Advisor. Please check the area(s) that are of interest to you:

❑ Participate in different working groups/committees/planning sessions
❑ Become a member on one of our Program Councils (Mental Health, Surgery, Medical, Cardiac, ED etc.)
❑ Become a member on the CEO Patient Family Advisory Council (application process involved)
❑ Share your story with health care providers, staff or Board members
❑ Participate in Short term projects (on an as need basis)
❑ Participate in Board governance committees (an additional screening process will be necessary)
❑ Other Special interests: _____

Please list times when you are available to volunteer (please check all that apply)

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Virtual/phone
❑Morning ❑ Afternoon

APPLICATION FOR
PATIENT AND FAMILY ADVISOR (PAGE 2 OF 2)

It is the responsibility of the Brant Community Healthcare System to protect its patients and staff from any disease or infection, which might be brought in by new volunteers. For this reason all new volunteers must, as a condition of volunteer placement, receive a passing health review as required by the System, in accordance with the Public Hospitals Act and other legislative Acts. Repeat examinations as required by legislation or the hospital are mandatory.

WOULD YOU CONSENT TO A HEALTH REVIEW? Yes ❑ No ❑

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE FOR WHICH A PARDON HAS NOT BEEN GRANTED? Yes ❑ No ❑

I hereby authorize the Brant Community Healthcare System to contact any of my references to make any inquiries required in determining my suitability for this volunteer position.

I acknowledge that all information listed here is true to the best of my knowledge. I understand that if and when I discontinue my role as a volunteer with the Brant Community Healthcare System that I must return my I.D. Badge.

Signature: _____ Date:

Please return this application form to: Patient and Client Experience Leader Brant Community Healthcare System
200 Terrace Hill Street
Brantford, ON N3R 1G9

If you have questions please contact:
Patient Experience/Relations at (519) 751-5544, Ext. 2395 or
patientrelations@bchsys.org

IN CASE OF EMERGENCY PLEASE NOTIFY:
Name: _____
Phone:_____
Relationship:_____

Personal information completed on this form is collected for operational and organizational purposes and is held in strict confidence. This information will be used to determine compatibility of needs and interest of volunteer with the needs and interests of the BCHS. Volunteer phone numbers and e-mail addresses may be given to BCHS staff to be used specifically to contact volunteers.