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## Patient Family Advisory Council Application Form

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Please complete this application form and submit via email or mail to:

Espanola Regional Hospital and Health Centre

Attention: Suzanne Thompson

825 McKinnon Drive

Espanola, ON

P5E 1A4

Email: [patientrelations@esphosp.on.ca](mailto:patientrelations@esphosp.on.ca)

For more information regarding the application process, please contact the Patient Advisory Council chairperson at 705-869-1420 ext. 3048.

### PERSONAL INFORMATION

Full Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Alternate Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_

Do you require any accommodation?

\_\_\_\_\_

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Please check the age range that best describes you:

- 18-30
- 30-50
- 50-65
- 65-75
- Over 75

### EMPLOYMENT STATUS

- Employed Part-time
- Employed Full-time
- Retired
- Seeking Employment
- Other

I am (please check all that apply):

- Currently a patient at ERHHC (Espanola Regional Hospital and Health Centre)
- Patient within the past 3 months
- Patient within the past 3-6 months
- Patient within the past 6-12 months
- Patient within the past 12-18 months
- A family member of a patient

**REASON FOR VOLUNTEERING**

Why are you interested in becoming an Espanola Regional Hospital and Health Centre (ERHHC) Patient and Family Advisor?

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Please, tell us about yourself; your skills, training, hobbies, spoken languages and your other volunteer experience.

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What are examples of things you would like to see ERHHC do differently to better serve patients and families that receive care?

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What are examples you have observed that ERHHC care providers are doing well to help patients and family members?

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**REFERENCES (Not family members or friends)**

Please provide ERHHC with three (3) references, who know you in a professional relationship.

1. Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Email address \_\_\_\_\_

Relationship \_\_\_\_\_

2. Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Email address \_\_\_\_\_

Relationship \_\_\_\_\_

3. Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Email address \_\_\_\_\_

Relationship \_\_\_\_\_

Eligibility Criteria & Commitment Expectations:

- 1. Must be 18 years of age.
- 2. Must be a resident of Espanola or live in the hospital's catchment area.
- 3. Must fulfill the requirements and responsibilities as outlined in our Patient Advisory Council Terms of Reference.

Conflict of Interest Disclosure:

Individuals serving on the Patient Advisory Council/ hospital committees must avoid conflicts between self-interest and their fiduciary duty to the hospital. Please identify below any relationships with a current employee of the hospital (or with another organization) which may create a conflict of interest, or have the appearance of a conflict of interest, by virtue of being appointed to the Patient Advisory Council.

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

Please review and check boxes before signing:

Have you ever been convicted of a criminal offence for which a pardon has not been granted?

no  yes (please provide details)

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

I understand that, upon acceptance into an advisory position, ERHHC requires that I submit results of a criminal reference check.

Are you currently or have you ever been involved in a legal challenge between yourself/your family and a hospital?  no  yes (please provide details)

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I understand that submitting this application and/or being interviewed does not guarantee a position as a Patient Advisory Council member.

I understand that prior to beginning as an advisor I must first sign a confidentiality agreement and the Code of Conduct.

I read and understand the Patient Advisory Council Terms of Reference.

I meet the eligibility criteria to be a member of the advisory council.

I agree to abide by the Mission, Vision, and Values of ERHHC.

I can commit time involvement in council activities.

I understand that I can withdraw my application at any time.

I have attached the name and contact information of a person who will provide a character reference.

I give ERHHC Patient Advisory Council permission to discuss my application with the above references.

## **DECLARATION**

By submitting this application form, I declare the following:

1. I meet the eligibility requirements as outlined above.
2. I have read, understand, and agree to comply to the following policies:
  - a) Patient Advisory Terms of Reference
  - b) Confidentiality Policy
  - c) Privacy Policy
3. I understand that my personal application submission will be subject to a formal screening process which may or may not result in my successful election or appointment to the Patient Advisory Council.

By checking the box below, you certify that you have read this application form, that you know and understand the meaning and intent of this agreement and that you are entering this knowingly and voluntarily.

I agree

Name: (signature)

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Date: \_\_\_\_\_