Patient and Family Advisory Council Application

Instructions

1. To apply to be a member of our Patient and Family Advisory Council, you must complete this application form and submit it with a copy of your current resume using the following information:

Attention: Executive Assistant
South Huron Hospital Association
24 Huron Street West
Exeter, ON N0M 1S2
Fax: 1-519-235-3405
Email: shha.administration@shha.on.ca

2. The application deadline will be determined annually.

3. For more information concerning this application process, please contact Executive Assistant @ 519-235-5151.

Applicant Contact Information

Full Name	Click here to enter text.	
Home Address	Click here to enter text.	
City/Town & Postal Code	Click here to enter text.	
Home Telephone Number	Click here to enter text.	
Cell phone Number	Click here to enter text.	
Work phone Number	Click here to enter text.	
Email Address	Click here to enter text.	
Preferred method of Contact	Choose an item.	Other: Click here to enter text.

The Little Hospital That Does

In the past 2 years have you or your family used the services of SHHA?

☐ Yes ☐ No

I am (please check):

☐ A current patient ☐ A former patient

☐ A family member of a current patient ☐ A family member of a former patient

☐ An interested community member

The care provided at SHHA was primarily: (Check all that apply)

☐ Admitted Patient ☐ Emergency Department ☐ Clinic/Out-patient

☐ Other (please comment) Click here to enter text.

Please check the age range that best describes you:

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

Why would you like to serve as an advisor? Click here to enter text.

What are some topics of special interest to you? Click here to enter text.

What are some specific things that SHHA care providers are doing well to help patients and family members? Click here to enter text.

What are some of the things you would like to see us do differently to better serve patients and families that receive care at SHHA? Click here to enter text.

Click here to enter text.

Click here to enter text.

Please specify the times when you are able to attend meetings: ☐ Daytime ☐ Evening
Click here to enter text.

When did you or your loved one receive care at SHHA? (Please check all that apply)

☐ 2014-present ☐ 2012-2014 ☐ 2010-2012 ☐ Before 2010

☐ None of the above

What services did you or your loved one receive at SHHA? (Please check all that apply)

☐ Emergency visit ☐ Medical Hospitalization

☐ Out-patient ☐ Rehabilitation

☐ Diagnostic Imaging ☐ Social Work

☐ Telemedicine/OTN ☐ Laboratory

☐ Registered Dietitians/Diabetes Clinic ☐ Other (please specify) Click here to enter text.

According to the Accessibility for Ontarians with Disabilities Act (AODA), do you require any accommodation for a disability?

☐ No ☐ Yes (please provide details) Click here to enter text.

Click here to enter text.

Eligibility Criteria & Commitment Expectations

1. Must be at least 18 years of age.
2. Must have been a resident of, or be employed or carry on business in the geographical area considered to be the catchment area of the hospital for at least three months prior to being considered as a potential member.
3. Expected to commit the time required to discharge the duties of board and committee membership (minimum time per month is on average 10-15 hours).
4. Must fulfill the requirements and responsibilities as outlined in our Patient and Family Advisory Council (PFAC) – Terms of Reference Policy # 02-030.

Conflict of Interest Disclosure

Individuals serving on the Patient and Family Advisory Council, hospital committees must avoid conflicts between self-interest and their fiduciary duty to the hospital. Please identify below any relationship 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 and Family Advisory Council.

Click here to enter text.

Please review and check ☐ before signing:

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

☐ Yes ☐ No (please provide details) Click here to enter text.

☐ I understand that, upon acceptance into an advisory position, SHHA requires that I submit the results of a criminal reference check for the vulnerable sector (18+ years old). More details are provided at the acceptance stage.

Are you currently or have you ever been involved in a legal challenge between yourself/your family and a hospital?

☐ Yes ☐ No (please provide details) Click here to enter text.

☐ I understand that submitting this application and/or being interviewed does not guarantee a position as a Patient and Family Advisor.

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

☐ I have read and understand the Rights of the Advisory Council as set out in the 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.

☐ I can commit time involvement in council activities.

☐ I understand that I may withdraw my application at any time.

☐ I understand that all successful Patient and Family Advisors will be required to complete a SHHA volunteer services orientation session.

☐ I have attached a current resume or brief biographical sketch.

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

☐ I give SHHA Patient and Family Advisors Council (or their designee) permission to discuss my application with the above reference.

Declaration

By submitting this application form, I declare the following:

1. I meet the eligibility requirements as outlined above
2. I have read, understood and agree to comply to the following Policies:
    a. Patient and Family Advisory Council (PFAC) – Terms of Reference 02-030 (in progress)
    b. Confidentiality Policy 19-002
    c. Privacy Policy 19-001
3. I understand that my personal application submission will be subject to a formal screening and selection process which may or may not result in my successful election or appointment to the Patient and Family Advisory Council.

Name Click here to enter text. Date Click here to enter a date.

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.

Please save this application electronically, and kindly submit via e-mail with your resume to:

shha.administration@shha.on.ca

Or, please print this application, and kindly submit with your resume to:

Attention: Executive Assistant, South Huron Hospital Association,
24 Huron Street West, Exeter, ON N0M 1S2 or **Fax: 1-519-235-3405**

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