NORTHUMBERLAND HILLS
HOSPITAL

Expression of Interest Form
NHH Patient and Family Advisory Council

Please return your completed application form by October 21, 2016 via one of the following methods:

Email: info@nhh.ca
Fax: (905) 372-4243
Mail: Office of the President and CEO, Northumberland Hills Hospital, 1000 DePalma Drive, Cobourg, ON, K9A 5W6
Drop-off: [Sealed envelopes only, please, accepted at the Main Entrance Inquiry Desk, NHH, weekdays between 7:00 AM to 4:00 PM, to the attention of the Office of the President and CEO]

Please note: there may be a risk when sending confidential information over an email system. If you have concerns about your privacy when using email, please mail or fax the document. If you have privacy-related question about this form and/or the hospital's use of the information it is gathering, please contact our Chief Privacy Officer at 905-377-7759 or (via email) privacy@nhh.ca

Thank you for your interest in this volunteer opportunity! Are you over the age of 18? Have you been a patient at NHH, or the family member of a patient, in the past three years? Would you/those who know you describe you as having the following three characteristics, considered essential for effective Advisors?

- ✓ **Objective and open-minded when considering the perspective of others, and able to think beyond your own personal experience**
- ✓ **Comfortable asking for clarification if you need it, and sharing your opinions**
- ✓ **Respectful of the opinions of others**

If you cannot answer YES to all of the questions above, the Patient and Family Advisor Role may not be for you. If you can answer YES, please proceed!

Name: _____

Contact Information:

Address			
City:		Postal Code:	
Telephone:		Cellphone:	
Email:			

Preferred method of contact:

☐ Telephone ☐ Cell phone ☐ Email

Are you a:

☐ Patient (within past 3 years)

☐ Family Member of a Patient (within past 3 years)

Can you speak and read English?

☐ Yes ☐ No

Other language(s) you speak: _____

The care provided at NHH was primarily as: (Check all the apply)

☐ Admitted Patient

☐ Clinic/Outpatient

☐ Emergency Department Patient

☐ Other _____

Within the last three years, what services have you (or your family member) used? (Check all that apply)

☐ Ambulatory Care Clinics
☐ Birthing Suite
☐ Cancer and Supportive Care
☐ Diagnostic Imaging
☐ Dialysis
☐ Emergency Department
☐ Inpatient Rehabilitation
☐ Intensive Care Unit
☐ Inpatient Units (Medical or Surgical Care)
☐ Mental Health
☐ Palliative Care
☐ Restorative Care
☐ Surgical Services

Would you be comfortable sharing your experience with the Council in order to make improvements?

☐ Yes ☐ No

Why would you like to serve as an NHH Patient and Family Advisory Council member?

_____

_____

_____

_____

_____

_____

Are there any specific health- or hospital-care issues that interest you?

_____

_____

_____

Please specify the time when you are able to attend meetings:

☐ Daytime ☐ Evening

☐ In person ☐ Teleconference

Are you currently a volunteer at NHH?

☐ No ☐ Yes

Have you participated in any NHH community/patient engagement activities in the past?

☐ No ☐ Yes

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

☐ No ☐ Yes (please provide details)

_____

_____

How did you hear about this opportunity?

☐ Website (if so, which one?) _____

☐ Local newspaper

☐ Local radio

☐ Social media post (if so, which one?) _____

☐ Recommendation from a care provider

Please confirm that you understand each of the following:

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

☐ I understand that, prior to beginning as an advisor, I would be required to submit the results of a criminal reference check (CRC) with the vulnerable sector search (18+ years old), sign an NHH Confidentiality Agreement and personal pledge to support the NHH Values of Integrity, Quality, Respect, Collaboration and Compassion.

☐ I understand that, as an advisor, I would be accountable to NHH and the Patient and Family Advisory Council.

I declare the above information to be true and complete to the best of my knowledge. I understand that a false statement may disqualify me or lead to my dismissal.

SIGNATURE: _____ **DATE:** _____

Thank you again for your interest in becoming an NHH Patient and Advisory Council member and for taking the time to complete this application. We will confirm receipt and be in touch shortly should you be selected for an interview.