Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital
*Partnering to keep healthcare close to home.*

# Patient and Family Advisor Application

## Instructions

To apply to be a volunteer Patient and Family Advisor at Alexandra Hospital Ingersoll (AHI) and Tillsonburg District Memorial Hospital (TDMH), please complete this application form and submit it with a copy of your current resume or biographical sketch and two references to:

Attention: Chief Nursing Executive, VP Clinical Services
167 Rolph Street
Tillsonburg, Ontario
N4G 3Y9
Fax 519-842-6733
Email: PatientFeedback@tdmh.on.ca

For more information concerning this application process, please contact the Patient Feedback Office at 519-842-3611 ext. 5336 or 519-842-1700 ext.8340

## Applicant Contact Information:

| | |
|---|---|
| Full Name | |
| Home Address | |
| City/Town & Postal Code | |
| Home Phone Number | |
| Cell Phone Number | |
| Work Phone Number | |
| Email Address | |
| Preferred Method of Contact | |

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**I am** (please check one)**:**

☐ A current patient
☐ A former patient
☐ A family member of a current patient
☐ A family member of a former patient
☐ An interested community member

**When did you or your loved one receive care at AHI/TDMH?** (Please check all that apply)

☐ 2020 - present
☐ Other _____

**What services did you or your loved one receive at AHI/TDMH?** (Please check all that apply)

☐ Emergency Visit ☐ Medical Hospitalization ☐ Out-Patient
☐ Rehabilitation ☐ Diagnostic Imaging ☐ Surgical
☐ Telemedicine/OTN ☐ Laboratory
☐ Registered Dietitian/Diabetes Clinic ☐ Other _____

**Why would you like to serve as an advisor?**

**What are some topics of special interest to you?**

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**What are some specific things that AHI/TDMH care providers are doing well to help patients and family members?**

**What are some of the things you would like to see us do differently to better serve patients and families that receive care at AHI/TDMH?**

**Please specify the times when you are able to attend meetings:**

☐ Daytime ☐ Evenings ☐ Virtual

**According to the Accessibility for Ontarian with Disabilities Act (AODA), do you require any accommodations for a disability?**

☐ No ☐ Yes (Please provide details)

## 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 candidate.

3. Expected to commit the time required to discharge the duties of a committee membership (minimum time per month is on average 2-4 hours).

4. Must fulfill the requirements and responsibilities as outlined in our Patient and Family Advisory Committee (PFAC)

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## Conflict of Interest Disclosure:

Individuals serving on the PFAC and/or other hospital committees must avoid conflicts between self-interest and their duty to the hospital as a member of the PFAC.
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 PFAC.

**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 a volunteer advisory position, TDMH/AHI requires that I submit the results of a Ontario Provincial Police (OPP) criminal reference check for Criminal Record and Judicial Matters Check (CRJMC). 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?

☐ No ☐ Yes (Please provide details)

☐ 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 first sign a Confidentiality agreement and the hospitals Code of Conduct.

☐ I meet the Eligibility Criteria to be a member of the advisory committee.

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

☐ I can commit time involvement in committee activities.

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

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

☐ I have attached current resume or brief biographical sketch.

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

☐ I give TDMH/AHI PFAC (or their designate) 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 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 PFAC.

| Signature | Date |
|---|---|
| | |

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