MICs Group of Health Services
PATIENT FAMILY ADVISOR APPLICATION FORM

PERSONAL INFORMATION

Name: _____ Date of birth: _____

Address: _____ City: _____ Postal Code: _____

Telephone (Home): _____ Telephone (Cell): _____

Email: _____

Why would you like to serve as an advisor?	
What are some issues of special interest to you?	
Do you have any skills or experience that would be advantageous?	

Check all that you would be interested in helping with:

❑ Reviewing patient and family satisfaction surveys ❑ Planning for the inpatient care experience

❑ Planning for the out-patient care experience ❑ Planning for the emergency care experience

❑ Developing/reviewing patient/family educational materials and website resources

❑ Participating in various committee meetings:

❑ Infection Control and Prevention ❑ Patient Care Team ❑ Oncology ❑ Medicine ❑ Surgery

❑ Emergency ❑ Other: _____

Have you been a patient/family of a patient at MICs within the last three years? ❑ Yes ❑ No

AVAILABILITY/COMMITMENT

I would be interested in participating at the following location(s):

❑ Anson General Hospital

❑ Bingham Memorial Hospital

❑ Lady Minto Hospital

Some meetings take place at 8:00am or 6:30pm. Most happen somewhere in between.
Please specify the times when you are able to attend meetings

Time/Day	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning							
Afternoon							
Evening							

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AGREEMENT

Please read and check ❑ before signing

❑ I understand that submitting this application and/or being interviewed does not guarantee a position as an Advisor

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

❑ I understand that prior to beginning as an advisor I must sign a confidentiality agreement.

❑ I understand that as an Advisor I will be accountable to the MICs Lead for the Patient Family Advisory Council.

Please provide the names and contact information of two references who are not related to you.

Applicant Signature: _____ Date: _____

Print Name: _____

Applicants who are selected for an interview will normally be contacted within 30 days of submission of the application form.

Personal information contained on this form is collected pursuant to the Public Hospitals Act and the Freedom of Information and Protection of Privacy Act (FIPPA), and will be used for the purpose of Patient/Family Advisor selection and placement at MICs. We will not share this information otherwise without permission from the applicant.

REFERENCES

NAME	CONTACT INFORMATION	RELATIONSHIP