

Expression of Interest Form NHH Patient and Family Advisory Council (PFAC)

Please return your completed application form using one of the following methods:

Email: <u>info@nhh.ca</u> Fax: 905-372-4243

Mail: VP, Patient Experience, Public Affairs and Strategic Partnership,

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 7:00AM to 4:00 PM, to the attention of the

office of the VP, Patient Experience, Public Affairs and Strategic

Partnerships.

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/caregiver of an NHH patient, in the past three years? Would you or those who know you describe you as having the following three characteristics, considered essential for effective advisors?

- ✓ Objective and open-minded when considering 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 the questions above, the PFAC Partner role may not be for you. If you answer YES, please proceed!

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Name:					
Contact Infor	mation:				
Address:					
City:				Postal Code:	
Telephone:				Cell Phone:	
Email:					
Preferred me	thod of co	ntact			
□ Telephone	□ Се	II Phone	□ Email		
Have you bee	en a:				
\square Family mer	mber of a p	n the past 3 yea atient at NHH (at NHH (within	(within the		
Can you spea ☐ Yes ☐ No	ık and read	l English?			
Other langua	ige(s) you s	peak:			
The care prov	vided at NF	IH was primari	ily as: (Ch	eck all that ap	oply)
 □ An Admitted Patient □ Clinic/Outpatient □ Other: 					
Within the la (Check all tha	_	ars, what serv	ices have	you (or your f	amily member) used?
 □ Ambulatory Care Clinic □ Cancer and Supportive Care □ Diagnostic Imaging □ Dialysis □ Emergency Department □ Inpatient Rehabilitation □ Integrated Stroke Unit □ Other: 			 □ Intensive Care Unit □ Inpatient Units (Medical or Surgical Care) □ Maternal/Child Care □ Mental Health □ Palliative Care □ Restorative Care □ Surgical Services 		
		ble sharing yo committee in			Council and/or your ments?

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Why would you like to serve as an NHH Patient and Family Advisory Council Partner?					
If you are applying for a specific opportunity on the Patient and Family Advisory Council, tell us a bit about how your experience/interests could be helpful to enhance our work in that area?					
Are there any other specific health or hospital-care areas that interest you?					
Please specify the time you are able to attend meetings:					
☐ Daytime ☐ Evening ☐ In-person					
Are you currently a volunteer at NHH?					
□ Yes □ No					
Have you participated in any NHH community/patient engagement activities in the					
past?					
\square No \square Yes (please provide details)					

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□ No □ Yes (olease provide details)
How did you hear a	bout this opportunity?
☐ Website (if so, whice ☐ Local online newson ☐ Local radio	ch one?) paper
	, which platform?) endation
$\hfill\square$ I understand that	you understand each of the following: submitting this application and/or being interviewed does not as an NHH PFAC Partner.
the results of a crimi (18+ years old), sign a	prior to beginning as a PFAC Partner I would be required to submit nal record check (CRC) with the appropriate vulnerable sector search n NHH Confidentiality Agreement and personal pledge to support tegrity, Quality, Respect, Teamwork and Compassion.
□ I understand that, and Family Advisory	as a PFAC Partner, I would be accountable to NHH and the Patient Council.
	information to be true and complete to the best of my stand that a false statement may disqualify me or lead to my
Signature:	Date:

Thank you again for your interest in becoming an NHH PFAC Partner 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.

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