



Client-and Family-Centred Care Client- and Family-Advisor Application

VOLUNTEER CONTACT INFORMATION			
Last Name	First Name	Middle initial	
Date of Birth (optional) (dd/month/yyyy):			
Address	City/town	Province	Postal Code
Telephone Numbers: Home		Other	
Email:			
In Case of Emergency Contact:		Relationship:	
Telephone Numbers: Home		Other	

VOLUNTEER HISTORY
<p>Have you previously volunteered for one of the sites within Eastern Health? If yes, indicate when and the role you held:</p>
<p>Please list any other volunteer positions you have held:</p>
<p>Indicate what best describes you (select one):</p> <p> <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Seeking work <input type="checkbox"/> Student <input type="checkbox"/> Other: </p>
<p>Indicate the highest level of education obtained:</p> <p> <input type="checkbox"/> University <input type="checkbox"/> Diploma <input type="checkbox"/> High school <input type="checkbox"/> Other: </p>
<p>Area of study:</p>

AVAILABILITY -When you are available to participate in committee activities?							
Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours							
<p>Are there other times of the year when you are <i>unable</i> to volunteer (e.g. summer, spring break, etc.)?</p> 							
<p>If accepted, how long are you able to commit to this committee? (select one):</p> <p> <input type="checkbox"/> Short term basis (up to 6 months) <input type="checkbox"/> Longer term basis(longer than 6 months) <input type="checkbox"/> Other - please describe: </p>							



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INTEREST & ABILITIES
<p>In the past three (3) years have you or your family member used the services of Eastern Health?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If yes, are/were you a:</p> <p><input type="checkbox"/> Patient <input type="checkbox"/> Family Member</p>
<p>Why are you interested in serving as a Client- and Family-Advisor?</p>
<p>Are there any specific issues or areas of interest for you in relation to the care provided by Eastern Health?</p>
<p>Are there any specific service or program areas that you are interested in being a Client- and Family-Advisor for?</p>
<p>Please identify any skills, experience, or knowledge you possess that would be advantageous to this role:</p>

<p>How did you find out about this Client- and Family-Centred Care Committee opportunity at Eastern Health?</p> <p><input type="checkbox"/> Brochure <input type="checkbox"/> Poster <input type="checkbox"/> Eastern Health employee <input type="checkbox"/> Referral from Health Care Professional <input type="checkbox"/> Eastern Health Website <input type="checkbox"/> Word of mouth <input type="checkbox"/> Volunteer Coordinator <input type="checkbox"/> Volunteer Event <input type="checkbox"/> Other - please describe:</p>
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CONFIRMATION
<p>Please read and check before signing:</p> <p><input type="checkbox"/> I understand that submitting this application and/or being interviewed does not guarantee a position as an advisor.</p> <p><input type="checkbox"/> I understand that Eastern Health requires that I undergo a Criminal Record Check <i>(Additional details to be provided during the interview)</i></p> <p><input type="checkbox"/> I understand that, prior to beginning as an advisor, I must sign a confidentiality oath.</p>
<p>Signature: _____ Date (dd/month/yyyy): _____</p>

<p>Parental/Guardian Consent is required for youth aged 14 to 17 years to volunteer</p> <p style="text-align: center;">I consent for my son/daughter to volunteer at Eastern Health</p> <p>Parent/Guardian Name (please print): _____</p> <p>Address _____ City/Town _____ Province _____ Postal Code _____</p> <p>Phone (home/work/cell): _____</p> <p>Signature: _____ Date (dd/month/yyyy): _____</p>
