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

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

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

How did you find out about this Client- and Family-Centred Care Committee opportunity at Eastern Health?
☐ Brochure ☐ Poster ☐ Eastern Health employee ☐ Referral from Health Care Professional ☐ Eastern Health Website ☐ Word of mouth ☐ Volunteer Coordinator ☐ Volunteer Event ☐ Other – please describe:

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CONFIRMATION
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 Eastern Health requires that I undergo a Criminal Record Check (*Additional details to be provided during the interview*) ☐ I understand that, prior to beginning as an advisor, I must sign a confidentiality oath.
Signature: _____ Date (dd/month/yyyy):_____

Parental/Guardian Consent is required for youth aged 14 to 17 years to volunteer

I consent for my son/daughter to volunteer at Eastern Health

Parent/Guardian Name (please print):

Address City/Town Province Postal Code

Phone (home/work/cell):

Signature: _____ Date (dd/month/yyyy):_____