



PATIENT AND FAMILY ADVISORY COUNCIL APPLICATION

To apply to become a member of our Patient and Family Advisory Council we ask that you to complete this application

Full Name:					
Home Address:					
City/Town & Postal Code:					
Home Phone Number:					
Cell Phone Number:					
Work Phone Number:					
E-mail Address:					
Preferred Method of Contact:					
Please Circle Age Category:	18-30	31-50	51-65	66-75	Over 76

Over the past two years what services have you or your family accessed, please check all that apply.

- | | |
|---|--|
| <input type="radio"/> Chemotherapy | <input type="radio"/> Outpatient Services |
| <input type="radio"/> Convalescence Care | <input type="radio"/> Rehab Services (Physio, OT, etc) |
| <input type="radio"/> Diagnostic Imaging (X-ray, CT, etc) | <input type="radio"/> Respite Care |
| <input type="radio"/> Emergency Services | <input type="radio"/> Surgical Services |
| <input type="radio"/> Hospitalization | <input type="radio"/> Telemedicine |
| <input type="radio"/> Labor & Delivery | <input type="radio"/> Other: |
| <input type="radio"/> Long Term Care | |

Which best describes you?

- Patient Family Member Caregiver

Why would you like to serve as member of the Patient & Family Advisory Council?

Topics of special interest to you?

Do you have any previous community involvement experience?

Yes No If Yes, please briefly tell us about your experience

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

Yes No Please Provide Details.

Instructions:

1) Submit application to:

RHC Patient and Family Advisory Council
Riverside Health Care
110 Victoria Avenue
Fort Frances, ON P9A 2B7
Email: riverside@rhcf.on.ca

If e-mailing please put "Patient and Family Advisory Council Application" in the subject line.

2) For more information concerning this application process, please contact:
Director of Nursing at 807-274-3261 ext 4511