



Patient Experience Advisor Application

VOLUNTEER CONTACT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth (dd/mm/yyyy)	
Street Address		City/Town	Province	Postal Code
Home	Cell	Work (optional)	Email Address	

EMERGENCY CONTACT INFORMATION

Name	Relationship to Volunteer	Home Phone	Cell Phone

In the past five (5) years have you or a family member used services of Central Health?

- Yes No

What would be the best available times for you to participate in committee activities?

- Daytime Evening

Are you interested in participating as an E-Advisor? (Internet access and email address required)

- Yes No

Why would you like to volunteer as a Patient Experience Advisor?

As a Patient Experience Advisor, do you have a specific service or program area you are interested in?

CONFIRMATION

Please acknowledge that you have read and understand the below affirmations:

- I understand that by submitting this application and/or being interviewed does not guarantee a position as an advisor
- I understand that Central 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/mm/yyyy)
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Please send completed form to: Suzanne House, Patient Experience Leader
James Paton Memorial Regional Health Centre
125 Trans Canada Highway
Gander, NL A1V 1P7