Erie St. Clair CCAC Patient Advisor Application Form

Date: _____

Name: _____

Street Address: _____

City/Postal Code: _____

Telephone: _____

Email: _____

Emergency Contact Information and Relationship: _____

In the past 5 years have you or your family used the services of the Erie St. Clair CCAC?

Yes ☐ No ☐

Why would you like to serve as an advisor?

What are some issues of special interest to you?

Do you have any gifts or talents that would be advantageous?

Meetings take place between 8:30 A.M. and 4:30 P.M. Please specify the times when you are able to attend meetings:

Daytime between _____ and _____

I would be interested in helping with: (you may check more than one box)

- ☐ Reviewing patient and family satisfaction surveys
- ☐ Developing/Reviewing patient/family educational materials and website resources
- ☐ Planning for in home experience
- ☐ Planning for the CCAC clinic experience

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- ☐ Ensuring patient safety and the prevention of medical errors
- ☐ Educating new employees and other staff about the experience of care and effective communication and support
- ☐ Improving the coordination of care, discharge planning and the transition from hospital to home
- ☐ Developing the uses for information technology, including electronic medical records
- ☐ School Health
- ☐ Palliative Care
- ☐ Nephrology
- ☐ Mental Health
- ☐ COPD
- ☐ Telehomecare/Telemedicine
- ☐ Hiring Interviews
- ☐ Other (please indicate)

Please read and check before signing:

- ☐ I understand that submitting this application and/or being interviewed does not guarantee a position as a Patient Advisor.
- ☐ I understand that, upon acceptance into an advisory position, CCAC requires that I submit the results of a Police Criminal Reference Check. More details are provided at the acceptance stage.
- ☐ I understand that prior to beginning as an advisor I must sign a confidentiality agreement.
- ☐ I understand that as an advisor I will be accountable to the CCAC Lead for Patient and Family Centred Care.

***Please provide the names and contact information of two references who are not related to you.**

Applicant's Signature: _____Date: _____

Print Name: _____

If applicant is under the age of 16, parent/guardian signature is required.

Parent/Guardian Signature_____ Date _____

Applicants who are selected for an interview will normally be contacted within 30 days of submission of the application form. *Personal information contained on this form is collected pursuant to the CCAC Act and the Freedom of Information and Protection of Privacy Act (FIPPA), and will be used for the purpose of Patient Experience Advisor selection and placement at CCAC. We will not share this information otherwise without permission from the applicant / guardian.*

***Please complete and submit to*:**

Kelley Robertson, Senior Lead, Patient & Family Centred Care & Chief of Professional Practice
Erie St. Clair CCAC, Chatham Site
712 Richmond St, Box 306, Chatham ON, N7M 5K4
Email: kelley.robertson@esc.ccac-ont.ca
Phone: 519-436-2222, ext. 7247 FAX: 519-436-2430