



## Patient Partner Council Member Application Form

Thank you for your interest in this volunteer opportunity to participate as a member of the Patient Partner Council at LWHA. Please complete and return this form to the Coordinator of Patient Experience by email to [patientexperience@lwha.ca](mailto:patientexperience@lwha.ca).

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email Address: \_\_\_\_\_

Please tell us why you would like to serve as a patient partner?

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Please describe some topics or issues that you are especially interested in:

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Do you have any special skills that you would be willing to share in your role as a member of the Patient Partner Council?

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Meetings will be held bi-monthly (April, June, September, November, January, March) and are currently the fourth Monday of the month from 10 am-noon except for July, August and December. Does this date and time work for you?  Yes  No. If not, please provide your availability below:

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### Please read and check boxes before signing:

- I understand that submitting this application and/or being interviewed does not guarantee a position as a member of the Patient Partner Council (PPC).
- I understand that prior to beginning as a PPC member I must sign a confidentiality, code of conduct, volunteer declaration agreement.
- I understand attendance on-site requires proof of full COVID vaccination immunization status provided to Occupational Health. I may also join the meetings virtually if unable to attend on-site.
- If completing patient facing activities, I understand I must obtain a vulnerable sector screening (police check) and complete an Occupational Health Immunization Clearance.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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