ROSS MEMORIAL HOSPITAL
Kawartha Lakes

Patient or Family Experience Partner Information Form

ALL INFORMATION IS CONFIDENTIAL Please print

How did you hear about the Patient Experience Partner Program?

_____

_____

Date of Birth:_____

Have you previously worked for RMH? ☐ Yes ☐ No

Last Name: _____ First Name: _____

Address: _____City:_____Postal Code: _____

Contact Numbers: Home:_____Work:_____Cell:_____

Email:_____ May we communicate with you using email? ☐Yes ☐No

Why are you interested in being a Patient Experience Partner?

_____

_____

_____

Describe any skills, experience, or training that you feel may be an asset to becoming a Patient Experience partner.

_____

_____

_____

I am a: ☐ Patient ☐ Family member of a patient ☐ Care partner

Within the past 2 years, what care services have you or your family member used? (check all that apply)

☐ Emergency	☐ Maternal newborn	☐ Mental Health
☐ Intensive care	☐ Palliative Care	☐ Ambulatory Care
☐ Medical	☐ Dialysis	☐ Health First
☐ Surgical	☐ Stroke care	☐ Surgical Day Care
☐ Rehabilitation	☐ Other:	

_____

I have an interest to work with:

_____

Please indicate the times you would be available for meetings (in person, teleconference etc.):

	MON	TUES	WED	THURS	FRI		
MORNING							
AFTERNOON							
EVENING							

Do you have any physical limitations or special needs we should know about? ☐ Yes ☐ No

If yes, please list _____

REFERENCES: (Please indicate an employment and a character reference, no relatives). Note: You must bring two completed reference forms to your interview.

1. Name: _____Telephone:_____

Address_____☐ Employer ☐Friend ☐Other_____

2. Name: _____Telephone:_____

Address_____☐ Employer ☐Friend ☐Other_____

IN CASE OF EMERGENCY, the person below may be contacted:

Name:_____ Telephone_____

Relationship:_____

Address:_____ City:_____

Have you been convicted of an offense under the Criminal records Act? ☐ Yes ☐ No

I hereby certify that all the information included in this application is true and complete.

Applicant's Signature:_____Date:_____

PLEASE RETURN THIS COMPLETED AND SIGNED APPLICATION FORM AND THE TWO COMPLETED AND SIGNED REFERENCE FORMS TO:

Director of Volunteer Services

Ross Memorial Hospital, 10 Angeline St. N, Lindsay, Ont. K9V 4M8

Or via Email: publicrelations@rmh.org

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