Patient Family Advisor Expression of Interest Form

All information collected is confidential.

Please complete this form if you are interested in becoming a Patient/Family Advisor for Nipigon District Memorial Hospital (NDMH), Nipigon District Family Health Team (NDFHT), and North of Superior Counselling Programs (NOSP)

We envision a thriving rural Local CARE health system where patients, families, staff, partners and community members Flourish Together – connected by trust, supported by purpose, and strengthened through CARE.

We strongly encourage engagement from Indigenous persons, women and men, youth, people from racialized communities, visible minorities, persons with disabilities, and people who identify themselves as LGBTQS+ to support informing and accountably sustaining a vibrant, healthy, safe and flourishing community. Upon request, accommodations due to a disability are available throughout the selection process. Additionally, we are identified as an English/French speaking facility and encourage bilingual candidates to apply.

Thank you, Miigwech, Merci - for considering to share your experiences and ideas to help improve and shape CARE delivery within a collaborative, supportive and respectful group with system leaders and staff all committed to making a difference in our local CARE services.

1. Previous Employee

Have you previously worked for NDMH, NDFHT or NOSP? (check one)

Yes ☐ If yes, when? _____ No ☐

2. Name and Address

mm/yy of birth: _____

First name: _____ Last name: _____

Street: _____ City/Prov: _____

Email Address: _____ Telephone: _____

3. In the last 2 years, I have been a: (check one)

Patient/Client ☐ Family Member ☐ Care Partner ☐ Friend of Patient/Client ☐

With: NDMH ☐ NDFHT ☐ NOSP ☐

4. To help us ensure diverse representation and create an inclusive council, we invite you to voluntarily self-identify. Your responses are confidential.

I identify as (please check all that apply):

Indigenous (e.g. First Nation, Metis, Inuit) ☐ A visible miniority ☐

LGBTQ2S ☐ A person with a disbility ☐

Prefer not to answer ☐ A Youth ☐

5. How did you hear about the Joint Patient Family Advisor program?

6. **Please describe why you are interested in volunteering your time as a Patient Family Advisor?**

7. **In addition to your experience with the care system as a patient/client, family member or loved one, please also describe any skills, experience, or training that you feel is an asset in becoming a Patient Family Advisor:**

8. **What services have you or your family member used? Please list all that apply. (ex. Emergency, Acute Care, Long Term Care, Family Health Team, mental health etc.)**

9. **I hereby certify that all information included in this Expression of Interest is true and complete.**

Name	Signature	Date

RETURN COMPLETED FORM BY MAIL TO P.O. BOX 37, 125 HOGAN ROAD, NIPIGON ON, P0T 2J0 OR BY EMAIL TO mboudreau@ndmh.ca