PATIENT AND FAMILY
ADVISORY COUNCIL MEMBERSHIP APPLICATION

Please complete this form to be considered as a candidate for the Patient and Family Advisory Council at Woodstock Hospital.

Name:_____
Address: _____ City: _____
Postal Code: _____ Email: _____
Telephone: _____

What is the best way to contact you and when? _____

Thank you for taking the time to complete this application. Please write a brief, but descriptive answer to the following questions in the space provided.

1.Describe your experience at Woodstock Hospital (which departments, including outpatient services or clinics, have served you and/or your family and approximately when).

2. What are some specific things that our health care professionals do/have done to help you and your family?

3. What are some of the things you would like our health care professionals to do differently or better to help you and/ or your family?

4. Why do you want to become a member of this council? When are you available for meetings?
___ Mornings ___Afternoons ___Evenings

Personal information contained in this form is collected pursuant to the Freedom of Information and Protection of Privacy Act (FIPPA) Sections 38(2) and 41(1) and will be used by the Selection Committee only. You may be contacted upon receipt of this application form to participate in a face-to-face meeting/interview.

Please email or mail this application to:
Woodstock Hospital
Attention: Chelsea Vella
310 Juliana Drive
Woodstock, ON N4V 0A4