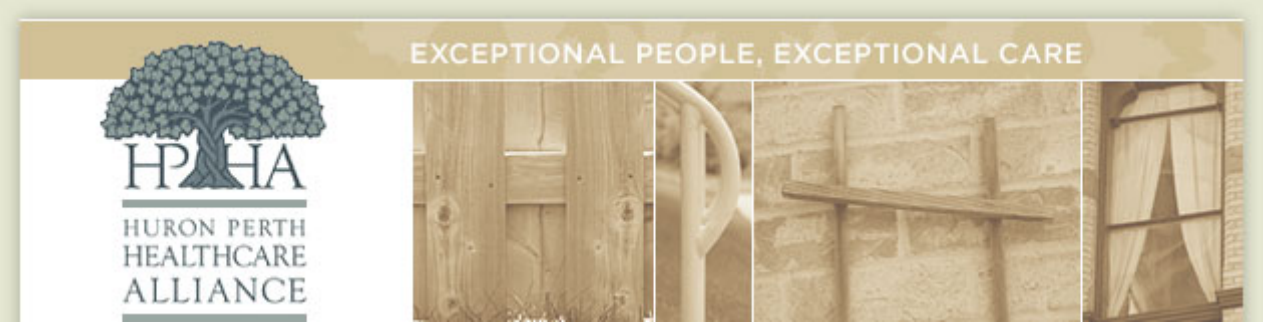

Patient Partner Application Form

Thank you for your interest in joining The Huron Perth Healthcare Alliance (HPHA) as a Patient Partner.

***First Name**

***Last Name:**

Mailing Address:

***Preferred Method of Contact:**

- ☐ Telephone
- ☐ Email Address:

***Have you been a patient, family member or caregiver of a patient at HPHA within the past two years?**

- ☐ Yes
- ☐ No

***If yes, please tell us a little about your experience including the hospital locations(s) and departments where care was provided.**

***Why would you like to serve as a patient partner?**

What areas, hospital programs or issues are you interested in?

- ☐ Committee Membership
- ☐ Project Participation
- ☐ Patient Experience Surveying
- ☐ Sharing Your Story

Other:

We recognize that our patient partners have busy lives; Please let us know how much time you may be able to commit (Approximately) - please check one:

- [ ] 1-2 hours/month
- [ ] 3-4 hours/month
- [ ] more than 4 hours/month

Other

Please read and check before submitting

I understand that by submitting this application and/or being interviewed does not guarantee a position as a Patient Partner.

*

Applicants Signature:

Date:

We will use personal information on this form to select and place Patient Partners at the Huron Perth Healthcare Alliance. We will not use the information in any other way without the permission from the applicant/guardian. We will protect your personal information, following the rules set out in the Public Hospitals Act and the Freedom of Information and Protection of Privacy Act (FIPPA).

Submit Cancel