The Centre for Family Medicine
Family Health Team
10B Victoria Street South
Kitchener, ON N2G 1C5
Tel: (519) 783-0020 | Fax: (519) 783-0034

Patient & Family Advisory Council

Application Form

Name:				Home Phone: Cell Phone:			
Email:							
My preferred method of contact is:	☐	Email	☐	Home Phone	☐	Cell Phone	
I am a (select all that apply):				Current patient	☐		
				Family member of the patient	☐		
				Caregiver of a patient	☐		
				Friend of a patient	☐		
Family Physician and/or Nurse Practitioner name:							
Please check the age range that best describes you:							
☐	18-30	☐	31-50	☐	51-65	☐	66-75	☐	76+
Why would you like to serve as an advisor for the Centre for Family Medicine Family Health Team?							
What are some areas of special interest to you?							
Are you currently employed? If so, who is your employer and what is your position?							
What skills and/or background will you bring to the advisor role? If you have experience on other boards, advisory councils or committees, please include this information:							

Please specify the times when you are able to attend meetings (select all that apply):							
☐	Mornings	☐	Lunch	☐	Afternoons	☐	Evening
According to the Accessibility of Ontarians with Disabilities Act (AODA), do you require any accommodations for a disability?							
☐	No	☐	Yes (please provide details)				

Please read and check that you agree to the following prior to submitting:	
☐	I have read and agree to the PFAC Terms of Reference
☐	I understand that submitting this application and/or being interviewed does not guarantee a position as a Patient & Family Advisor
☐	I understand that, prior to beginning as an advisor, I must first sign a confidentiality agreement
☐	I meet the eligibility criteria to be a member of the advisory council
☐	I can commit to the time required for the council
☐	I understand that I can withdraw my application at anytime
☐	I have no reservation in providing two (2) character references and provide permission for these references to be contacted to discuss my application

References - please provide the names and contact information of two references that are not related to you:

Name:	Contact Information:
Name:	Contact Information:

Personal information contained on this form is collected pursuant to the Freedom of Information and Protection of Privacy Act (FIPPA), and will be used for the purpose of selection for the Patient and Family Advisory Council with CFFM.
We will not share this information otherwise without permission from the applicant.
The Centre for Family Medicine Family Health Team provides an equal opportunity to all applicants.

Please return this application via email, fax or mail to:
Sylvia Decker, Site/*Operations Manager*
Centre for Family Medicine Family Health Team
10B Victoria Street South, Kitchener, ON N2G 1C5
Fax – 519-783-0034 Email: sylvia.decker@family-medicine.ca