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Extraordinary Caring. Every Person. Every Time.

Niagara Health Engagement Network

Processing Your Patient Partner Application

Thank you for your interest in becoming part of the Niagara Health Engagement Network as a Patient Partner. We can only consider completed application packages containing the following mandatory documents:

☐ A completed application form (mandatory for all new Patient Partners)
☐ Two completed reference forms (mandatory only for new Volunteers)

Optional is the inclusion of the following:

☐ Cover Letter expression of interest (optional)
☐ Resume (optional)

Please return the completed application form to:

patientpartners.NHEN@niagarahealth.on.ca

Or by mail to:

Patient Partnerships & Relations
Niagara Health
1200 Fourth Avenue
St. Catharines, ON
L2S 0A9

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Patient Partner Application Form

Name:____
First name Last Name

Home Address: ____

City: ____________________ Province:______________ Postal Code:________________

Home telephone #: ________________________ Cell Phone #: ____________________

Email:____

Age Range: ☐ Under 18 ☐ 18-34 ☐ 35-49 ☐ 50-69 ☐ 70+

Education Level: ☐ High School ☐ Undergraduate ☐ Diploma/Certificate ☐ Post Graduate/Certificate

Preferred method of contact (please select one): ☐ Home phone ☐ Cell phone ☐ Email

Emergency Contact Information:____
First name Last Name

Phone #:_________________________ Relationship: ________________________

Do you have any medical conditions that we should be aware of? ☐ Yes ☐ No
If yes, please describe: ____

The following questions will help us get you know you better

1. Are you…. (check all that apply)
   ☐ A patient who has received care at Niagara Health
   ☐ A family caregiver of a patient who has received care at Niagara Health
   ☐ A community member wishing to volunteer
   ☐ Coping well with your hospital experience
   ☐ Willing to talk about your experiences
   ☐ Able to listen well and enjoy working with others
   ☐ Able to attend daytime and early evening meetings

2. When was your care experience or your family members care experience at Niagara Health? (check all that apply)
   ☐ 2020
   ☐ 2019
   ☐ 2018
   ☐ 2017
   ☐ 2016
   ☐ 2015
   ☐ 2014 (or before)
   ☐ Not applicable (I never received care at Niagara Health)

Which hospital(s) and program provided care to you or your family?

☐ St. Catharines Site ________________________________(unit/program)
☐ Greater Niagara General Site ________________________________(unit/program)
☐ Welland Site ________________________________(unit/program)
☐ Port Colborne Site ________________________________(unit/program)
☐ Douglas Memorial Site ________________________________(unit/program)

4. Do you **currently** have any formal affiliation with Niagara Health? Check all that apply.

☐ Volunteer Resources
☐ Foundation
☐ Research
☐ Student Placement
☐ Employee
☐ Vendor
Other (please specify): ______________________

5. In the **past**, have you had any formal affiliation with Niagara Health? Check all that apply.

☐ Volunteer Resources Date:________________
☐ Foundation Date:________________
☐ Research Date:________________
☐ Student Placement Date:________________
☐ Employee Date:________________
☐ Vendor Date:________________
Other (please specify): ______________________

6. How much time are you able to commit to being a Patient Partner? Check one.

☐ Less than 1 hour per month
☐ 1-2 hours per month
☐ 3-4 hours per month
☐ More than 4 hours per month

7. How do you want to help? Check all that apply.

☐ Participate in discussion groups about patient care, quality improvement, safety and policies
☐ Review or help create materials we give to patients
☐ Participate in discussion groups about hospital design and way finding
☐ Serve on workgroups or committees
☐ Share your story with staff, health care providers and leaders

8. Do you have any experience or expertise that would add to the diversity of the Patient Partner group?

9. Is there anything else you would like to share about yourself?

Declaration:

1. I understand that any offer of a volunteer position would be conditional upon the following:
    a. Following Niagara Health "Communicable Disease Surveillance Program", everyone carrying out activities in patient care areas must have a 2-step TB test. Documented proof of immunity to chicken pox, measles, mumps and rubella is also required;
    b. My photograph being taken for identification purposes;
    c. Police Criminal Record Check
2. I understand that if accepted for a volunteer position, I agree to comply with the conditions of the volunteer position and the policies of the Hospital.
3. I understand that if any statements made by me on this or any other document are untrue or misleading, this application may be rejected or will constitute sufficient grounds for termination of service.
4. I will not disclose or use, during or subsequent to my volunteer service with Niagara Health, any information (written, verbal, electronic, or other form) relating to patients, employees, volunteers or Hospital business.

I give consent for my provided contact information to be shared within Niagara Health.

Signature:____ Date (mm/dd/yyyy):________________________