Patient Advisory Council
Application Form

Name:	Home Phone: Cell Phone:
Email:	
My preferred method of contact is: ☐ Email ☐ Home Phone ☐ Cell Phone	
I am a current patient of the DAFHT	
I have accessed DAFHT providers (either presently or in the past)	
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+	
Please explain the reasons you would like to serve as an advisor for the Dufferin area Family Health Team?	
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.
Do you have any dietary restrictions or food allergies? We will be providing a light meal during the meetings.
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 understand that submitting this application and/or being interviewed does not guarantee a position as a Patient Advisor.
I understand that, prior to beginning as an advisor, I must first review the DAFHT Privacy Policy and sign a confidentiality agreement.

DUFFERIN AREA FAMILY HEALTH TEAM

I will provide constructive advice and will work collaboratively with other members of the committee.
I will respect diversity and differing opinions.
☐ I can commit to the time required for the patient advisory, which would be meeting three times per year from approximately 6-8 p.m.
I understand that I can withdraw my application at anytime.
I have no reservation in providing two 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 Advisory Council with DAFHT.
We will not share this information otherwise without permission from the applicant.
Dufferin area Family Health Team provides an equal opportunity to all applicants.

Please return this application by fax or email to:
Lianne Davies, Executive Director
Dufferin Area Family Health Team
l.davies@dafht.ca
Fax: 519-938-8128