Cornwall Community Hospital
Hôpital communautaire de Cornwall

PATIENT CAREGIVER EXPERIENCE ADVISORY COUNCIL (PCEAC) APPLICATION FORM

If you have any questions about this form please contact the Director Quality & Medicine Services (613-938-4240 extension 3340)

First and Last Name:			
Street Address			
City		Postal Code	
Email Address			
Home Phone		Mobile Phone	
Preferred Contact	☐ Home Phone	☐ Mobile Phone	☐ Email

I am interested to sit on the Patient Caregiver Experience Advisory Council(PCEAC) as a:

☐ Patient/former patient
☐ Family member of a patient
☐ Caregiver of a patient

1) **My most recent experience with the Cornwall Community Hospital was:**
☐ Within the last year ☐ Within the last 2 years ☐ Over 2 years ago

2) **I speak the following language (s)**
☐English ☐French ☐Other

3) **I or my family member received care from these health services or health care teams *(check all that apply)***
☐ Diagnostic Services
☐ Inpatient Services
  ☐Critical Care
  ☐Medicine/Rehab
  ☐Surgical
☐Women & Children's Health
☐ Emergency Department
☐ Mental Health Services
  ☐Inpatient
  ☐Community Programs - Adult
  ☐Community Programs - Children
☐ Other *(please Specify)*

4) **Each month, I am able to volunteer this much time(check one)**
☐ More than 4 hours per month ☐ 3 to 4 hours per month
☐ 1 to 2 hours per month ☐ Less than 1 hour per month

5) **I am available to serve on the PCEAC for a minimum of two (2) years**
☐ Yes ☐ No

6) **Please specify times when you are available to attend meetings:**
☐Morning ☐Afternoon

7) As a member of PCEAC I would like to help (check all that apply)

☐ Develop or review informational materials for patients and family members

☐ Improve the patient and family role in health care decision-making

☐ Improve health care services

☐ Educate or train health care staff and clinicians by sharing my health care experience story

☐ Review policies, programs and practices which affect patient care services and offer suggestions for improvement

☐ Other topics (please describe)

Please return your completed form to feedback@cornwallhospital.ca or by mail to: Cornwall Community Hospital
840 McConnell
Cornwall, ON K6H 5S5
Attention: Patient Relations