Patient & Family Advisory Council (PFAC)
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	☐

Name of Family Physician:

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 STAR Family Health Team's PFAC?

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 this Application:	
☐	I meet the eligibility criteria to be a member of the advisory council
☐	I have read and agree with the information outlined in the "Summary of Details" about the STAR Family Health Team PFAC.
☐	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 can commit to the time required for the council as outlined in the "Summary of Details"
☐	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 the STAR Family Health Team (STAR FHT)
We will not share this information otherwise without permission from the applicant.
The STAR Family Health Team provides an equal opportunity to all applicants.

Please return your completed application by August 15, 2021 to your family physician's clinic, or by mail or fax to the Attention of Monique Hancock, Executive Director:
STAR Family Health Team
700 O'Loane Ave., Stratford, ON N5A 6S6
fax: 519-273-0371