

Experience Partner Application Form

Name	
Address	
City/Postal Code	
Telephone	
Email	
Emergency Contact (Name and Telephone Number):	

In the past have you, a family member or friend used Providence Care's services?

Why would you like to volunteer as a Providence Care Experience Partner?

What are some of your interests regarding the present day health care system?

I would be interested in helping with (you may check more than one box):

- Patient, client, resident and family led feedback forums
- Educating Providence Care staff, volunteers and guests about patient, client, resident and family-centred care and the role of Experience Partners
- Reviewing policies and procedures
- Participating in working groups, committees and other initiatives

Availability

We recognize that our Experience Partners have busy lives. Our mandatory monthly meeting is the 3rd Tuesday of every month.

Are you able to commit to the monthly meetings? Yes No

Are you able to commit to a one-year term? Yes No

Please let us know your ongoing daytime availability:

I understand that submitting this application and/or being interviewed does not guarantee a position as a Providence Care Experience Partner.

Thank you for your interest in our program.

Providence Care Experience Partner Team