Yea & District Memorial Hospital Consumer Advisory Group /Committee Application

Personal Details:

First Name:

Last Name:

Street Address:

City:

Post Code:

Mailing Address:

(if different from above)

Phone Number(s):

Email:

Preferred contact method:

□ Mail □ Email □ Phone

Do you speak any languages, other than English?

□ No

□ Yes

If yes, language(s): _____

Which is your age range:

(please tick)

□ 16 – 18 years

□ 18 – 25 years

□ 26 – 35 years

□ 36 – 45 years

□ 46 – 55 years

□ 56 – 65 years

□ 66 – 75 years

□ > 75 years

Are you currently representing, or have you previously represented, the community as a consumer representative at another health service?

□ No

□ Yes

Please list any community activities you may be involved in. (for example, Rotary, Lions Club, social groups, church groups, etc)

_____

_____

What support will you need from to be effective as a Yea & District Memorial Hospital consumer representative?

□ Large Printed Materials

□ Wheelchair accessible vehicles

□ Interpreters

□ Dietary

□ Other:

Please mark your areas of interest:

□ Looking at consumer complaints and compliments, checking any patterns, suggesting improvements and seeing what make a difference

□ Telling your story – for the training of staff, orientation and/or getting the consumer perspective across. This can be made anonymous, if you prefer.

□ Mentoring and/or assisting other consumers with information / lived experience or navigating the health care system

□ Reviewing written information for consumers

□ Assist in the design / redesign of services

□ Assist in the design / redesign of facilities and/or buildings

□ Be a consumer representative on a formal Committee

□ Clinical focus

□ Non-clinical focus

□ Be a consumer representative on a more informal committee or working group

□ Other: please provide further detail

Yea & District Memorial Hospital services of interest:

□ Aged care

□ Allied Health Services

□ Community Health

□ Consumer and/or Carer issues

□ Cultural Diversity

□ Disability Services

□ Urgent Care

□ Health Promotion Initiatives

□ Other:

Availability: □ Once / one off

□ Two to eleven times per year

□ Quarterly

□ Monthly

Best times of the: Day: (times or morning/afternoon, after hours)

_____

Week: (days of the week) _____

Year: (if relevant 'not July to August when we go away') _____

_____

What is your connection to Yea & District Memorial Hospital?

□ I am a patient / consumer

□ I am a carer

□ I am a past patient / consumer

□ I am a relative of a patient / consumer

□ I am a local community member

Questions

1. Why are you nominating for this Committee / Working Party? Why does it interest you?

2. What experience have you had as a consumer representative?

3. If successful, how will you consult with health consumers?

4. Please provide any other information relevant to your nomination, for example professional qualifications, work history or other experience related to the area or to health consumer issues more generally.

STATEMENT / AGREEMENT

Consumer representative's statement:

I understand that this information is being provided to the Quality service and will also

be kept on file at Yea & District Memorial Hospital.

I understand that as a Consumer Representative my involvement does not attract any salary.

If I am successful, I agree to the requirements of the position as outlined in the Consumer Representative Application Pack.

Signature: _____

Date: