EM/ANB Patient and Family Advisor

Application Form

Thank you for your interest in becoming a volunteer patient and family advisor with EM/ANB Inc.

To Become an EM/ANB Volunteer Patient and Family Advisor

Please complete and return the attached application and supply two (2) (*non family member*) references. Those providing references can mail the reference to the address provided on the form or return to the applicant in a sealed envelope to submit with application.

We will acknowledge receipt of your full application.

Successful applicants will be asked to successfully complete a Criminal Reference Check.

You will be asked for a commitment of one (1) year minimum.

As a member of the patient and family advisor team, you will receive a complete orientation.

If you have any questions please do not hesitate to contact us at:

EMANB.pf@medavienb.ca or (506)855-2055.

EM/ANB Patient and Family Advisor Application

Name: _____ _____
(please print) (Surname) (First name)
Address: _____

Postal Code: _____ **Email:** _____

Telephone: (H) _____ **(C)** _____ **(W)** _____

Languages: ☐ French ☐ English ☐ Other_____

Employer (present and previous): _____

Why do you wish to become a Patient and Family Advisor?

_____
_____
_____

Have you or a family member ever been a patient of Ambulance New Brunswick and/or the Extra-Mural Program ?_____

Please indicate when you were a patient or family member of a patient? _____

Please indicate times that you may be available:

Availability	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

I hereby certify that the facts set forth in this application are true and complete. I hereby authorize an EM/ANB representative to contact my references.

_____ _____
Signature Date

CONFIDENTIAL REFERENCE FORM

Please complete this form and email to: EMANB.pf@medavienb.ca
Or **mail directly** to: EM/ANB Patient and Family Advisory Program
In care of Coordinator Policies, Procedures and Accreditation
210 John Street, suite 101, Moncton NB, E1C 0B8

APPLICANT'S NAME:_____ DATE:_____

REFERENCE INFORMATION

Referee's Name:_____
(Please print in full first and last names)

Email Address:_____

Phone:_____

Position: _____

I have known the applicant for _____ year(s) in the capacity of _____
(e.g. Friend, Coach, Teacher, Supervisor, Employer.)

Signature: _____

PLEASE NOTE: The individual named above has applied to volunteer with Ambulance New Brunswick and the Extra-Mural Program as a patient and family advisor. As a patient and family Advisor, this individual would have contact with patients, their families, general public and are also required to work co-operatively with other volunteers or staff. In patient related areas patient/family advisors need to feel at ease while interacting with children, youth, adults and seniors as well as offering support to their families. Any information you provide will be treated in confidence.

• How well does the applicant work as part of a team?	Comments:
• How does the applicant relate to people?	Comments:
• If faced with a stressful situation, how would the applicant respond? (Become discouraged, avoid the situation, persevere or seek assistance)?	Comments:
• How does the applicant handle conflict and pressure?	Comments:
• Would you recommend the applicant for a position of trust?	Comments:
• Is the applicant a reliable/punctual individual?	☐ Yes ☐ No ☐ Sometimes
• How does the applicant handle confidential information?	Comments:
• Is there anything you feel we should be aware of in accepting the applicant as a patient/family advisor?	Comments:
• In your opinion, would you recommend the applicant to be a volunteer patient and family advisor in a healthcare program? ☐ Yes ☐ No	

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