



Health Care Advisor Expression of Interest

Name _____

Phone Numbers

Home _____ Work _____

Cell _____

Email Address _____

Preferred Contact Method

Home phone Work phone Cell phone Email

When are you available?

Daytime Evening Weekend

How did you hear about this opportunity?

Newspaper Radio Word of mouth Health Care Provider
 Brochure Website Other

The Northern Health Region is interested in ensuring it is representative and inclusive of Manitoba's diverse population. We are inviting you to list the group(s) you identify with (e.g. First Nation, Metis, Newcomer, Persons living with a disability, Young Adult, Transgender, etc.).

Will you require any supports in order to participate (e.g. translator, note-taker, amplification, etc.)?

Have you received care, or supported a loved one in receiving care over the last 5 years?

Yes No

Some programs may need more specific information about type of diagnosis or type of care

Which of the following opportunities would interest you?

- Ongoing and regular commitment to an advisory body
- Participating in periodic focus groups
- Participating on committees with health professionals to help improve services

- Participating from home (e.g. answering surveys, reviewing educational documents)
- Participating in program and policy development
- Sharing my personal health care story to help improve services
- Other:

What aspects of health care interest you the most (e.g. patient safety, health promotion, making the system better, etc.)?

Would you be interested in participating in any other type of initiatives?

- Yes No Maybe

If you live in rural Manitoba, would you be interested in participating virtually, such as via Telehealth?

- Yes No

Employment Status

- Employed full time Employed part time Unemployed
 Retired Homemaker/Caregiver Student

What kind of work do/did you do?

Do you have any special skills or training (e.g. comfort with interpreting data, familiar with medical terminology, giving presentations, etc.)?

Tell us why you are interested in participating as a Health Care Advisor.

References (not family)

- | | |
|---------------|--------------------|
| 1. Name _____ | Phone Number _____ |
| 2. Name _____ | Phone Number _____ |
| 3. Name _____ | Phone Number _____ |

I am willing to sign a confidentiality form

Questions? Call: (204) 687-9320 Toll-free: 1-888-340-6742

Send your completed form to:

Patient Experience Coordinator
Box 340
Flin Flon General Hospital
3rd Avenue & Church Street
Flin Flon, Manitoba R8A 1N2
Or via email to patientexperience@nrha.ca