

Application Form for Child & Youth Advisors

Name:			_ Date of Birth:	
Name:(Last) Address:	(First)	(MI)	_	(YYYY/MM/DD)
City:			ostal Code: _	
Email Address:				
Home Phone:		Cell Phone	:	
What is the best way to	contact you and who	en?		
Name(s) of Parents/Ca	regivers:		_ Cell/Work F	Phone:
Name(s) of Parents/Ca	regivers:		Cell/Work Phone:	
Any Allergies (Food, en	vironmental, etc):			
Emergency Information	1:			
Contact:	Relations	hip:	Cell/Work	Phone:
The dates of my activ	e care experience at	Children's includ	de: (Check all	that apply)
□ 2011 to present	□ 2007 to 20	10 🗆 2003	3 to 2006	☐ Before 2003
Within the past three (Check all that apply)	years, what Childre	en's Hospital prog	rams and sei	rvices have you used?
☐ Acquired Brain In☐ Bleeding Disorders/Hemo Cardiology Cystic Fibrosis Diabetes Emergency Room Endocrinology Gastroenterology	philia	enetics lematology Mental Health Metabolics lephrology leurology leurosurgery MCU Incology	☐ PCCU ☐ Radiol ☐ Rheum ☐ Respir ☐ Transp	ogy natology ology olant

1.	Please tell us why you are interested in becoming a Child & Youth Advisor:
2.	What are some of the specific things that Children's Hospital's health care professionals do/have done to help you and your family?
3.	What are some of the things you would like Children's Hospital health care professionals to do differently or better to help you and your family?
4.	Is there anything else you would like to share?

Please write brief but descriptive answers to the following questions in the spaces provided.

How did you hear about the Children's Hospital Child & Youth Acapply)	dvisory Council? (Check all that
□ Poster/Brochure □ Hospital Staff □ Family/Friends	□ Website
Applicant's Signature:	Date: (YYYY/MM/DD)
I agree to allow my childto Child & Youth Advisory Council. I will do my best to encourage him/hway.	
Parent/Caregiver's Signature:	Date: (YYYY/MM/DD)
All information contained on this form is considered confidential and Youth Advisory Council only. You will be contacted upon receipt of th	5
Please email, fax or drop off this application to:	
Jill Sangha, MSW RSW CTS Patient & Family-Centred Care Specialist,	

Jill Sangha, MSW RSW CTS
Patient & Family-Centred Care Specialist,
Paediatric Family Resource Centre B1-006
Children's Hospital London Health Science Centre
800 Commissioners Road East
London, Ontario N6A 5W9
Tel 519 685-8500 extension 50102
Fax 519 685-8103
Jill.Sangha@lhsc.on.ca

Last Updated: 2013/08/06