



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

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?

**How did you hear about the Children’s Hospital Child & Youth Advisory Council?** (Check all that apply)

- Poster/Brochure     Hospital Staff     Family/Friends     Website

**Applicant’s Signature:** \_\_\_\_\_ Date: \_\_\_\_\_  
(YYYY/MM/DD)

I agree to allow my child \_\_\_\_\_ to participate as a member of the Child & Youth Advisory Council. I will do my best to encourage him/her to participate in a meaningful way.

**Parent/Caregiver’s Signature:** \_\_\_\_\_ Date: \_\_\_\_\_  
(YYYY/MM/DD)

All information contained on this form is considered confidential and is intended for use by the Child & Youth Advisory Council only. You will be contacted upon receipt of this application form.

Please email, fax or drop off this application to:

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](mailto:Jill.Sangha@lhsc.on.ca)