Peterborough Regional Health Centre

Experience Partner Application

PRHC
PATIENT PARTNERSHIPS

To be eligible to be an Experience Partner, you must have received care or supported someone who received care at Peterborough Regional Health Centre (PRHC) in the last five (5) years.

Examples include an inpatient stay, outpatient clinic visit or getting a test, image or procedure.

Have you or someone you have supported received care at PRHC within the last five (5) years?

☐ Yes ☐ No *If yes, continue with application.*

Name:	Date of birth (DD/MM/YYYY):	Current or previous PRHC employee? ☐ Yes ☐ No
Street address:	City:	Postal Code:
E-mail address:	Phone number(s):	Preferred contact method: ☐ Phone ☐ Email

How did you hear about the Patient Partnership program?

How would you like to be involved? Please check all interest areas:

☐ I would like to contribute virtually (by telephone or by email, for example, completing surveys or reviewing documents and providing feedback)

☐ I would like to attend in-person or virtually meetings to provide input on matters which impact the experiences of patients and those who support them

☐ Other (please describe): _____

Describe any skills, experience or training that you feel will be an asset as an Experience Partner:

At PRHC, I have been a: ☐ Patient ☐ Family member/supporter/caregiver of a patient

Within the past two years, what care services have you or the person(s) you were supporting used that you wish to provide your input on? (For example: Emergency Department, Cancer Care, Diagnostic Imaging, Intensive Care (ICU), Palliative Care, etc.)

Please indicate times that you would be available for meetings (if applicable)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

PRHC is committed to promoting equity, diversity, and inclusion. To help support this work, we strive to include diverse perspectives across our Patient Partnerships Program. The following optional questions help us understand the various lived experiences applicants have and perspectives they may provide and are helpful in ensuring diverse perspectives and experiences are included. All information is confidential and will be reviewed by one or two members of the Quality & Patient Partnerships team.

Do you identify with any of the following statements? Please select all that apply.

- ☐ I do not wish to answer/Not Applicable
- ☐ I was born outside of Canada
- ☐ I identify as LGBTQ2S+
- ☐ I have experienced homelessness or housing insecurity
- ☐ I am working full-time
- ☐ I have dependents living in my home
- ☐ I have experienced addiction myself or as a close family member/friend living with addiction
- ☐ English is not my first language
- ☐ I am living with a disability and/or chronic illness

Which of the following best describes you? Please select all that apply.

- ☐ Arab, Middle Eastern or West Asian (e.g. Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.)
- ☐ Black (e.g. African, Afro-Canadian, Afro Caribbean, etc.)
- ☐ East Asian (e.g. Chinese, Korean, Japanese, Taiwanese, etc.)
- ☐ Jewish
- ☐ Latin American (Hispanic or Latin American descent)
- ☐ South Asian (e.g. Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.)
- ☐ Southeast Asian (e.g. Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.)
- ☐ White (e.g. European descent)
- ☐ Indigenous descent (First Nations, Métis Inuk/Inuit)
- ☐ Another race/ethnic group (please specify): _____
- ☐ Do not know
- ☐ Prefer not to answer

We recognize that all patients, family members, or those who support them have diverse experiences. If there are other comments you wish to provide regarding your experiences, please outline them below:

Do you have any physical limitations, special needs, dietary preferences or allergies we should know about? ☐ Yes ☐ No If yes, please list:

ALL INFORMATION IS CONFIDENTIAL

I hereby certify that all information included in this application is true and complete.

Applicant's Signature: _____ Date (DD/MM/YYYY): _____

PLEASE RETURN THIS COMPLETED APPLICATION FORM TO:
Quality & Patient Partnerships, W5700
Peterborough Regional Health Centre, 1 Hospital Drive, Peterborough, ON, K9J 7C6
ptexperience@prhc.on.ca | 705-743-2121 x. 3224