



## 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:  
[EM/ANBPatientFamilyEngagement@Medavienb.ca](mailto:EM/ANBPatientFamilyEngagement@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 **mail directly** to:  
EM/ANB Patient and Family Advisors  
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: \_\_\_\_\_ I have known the applicant for \_\_\_\_\_ year(s) in the capacity  
(Please print in full first and last names) of \_\_\_\_\_

Email Address: \_\_\_\_\_ (e.g. Friend, Coach, Teacher, Supervisor, Employer.)

Phone: \_\_\_\_\_ Signature: \_\_\_\_\_

Position: \_\_\_\_\_

**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	



### CONFIDENTIAL REFERENCE FORM

Please complete this form and **mail directly** to:

EM/ANB Patient and Family Advisors

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)

I have known the applicant for \_\_\_\_\_ year(s) in the capacity

of \_\_\_\_\_

Email Address: \_\_\_\_\_

(e.g. Friend, Coach, Teacher, Supervisor, Employer.)

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Position: \_\_\_\_\_

**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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/family advisor in a healthcare program? <input type="checkbox"/> Yes <input type="checkbox"/> No	