The Sydney children's Hospitals Network
care, advocacy, research, education

EXPRESSION OF INTEREST FORM
SCHN PATIENT, PARENT/CARER ADVISORY COUNCIL

APPLICANT CONTACT DETAILS	
Family name	
Given names	
Residential address	
Postal address	
Preferred phone number	
Email	

APPLICANT BACKGROUND	
It is important that the Network partner with families who have a broad range of experiences and represent the diversity within the community (*please select all the categories below that are relevant).*	
Are you of Aboriginal or Torres Strait Islander origin?	☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ No
Do you identify with a culturally and linguistically diverse background?	☐ Yes - *please specify country of origin and language spoken at home* _____ ☐ No
I am best described as a:	☐ Parent / Carer of a child / young person at the Sydney Children's Hospital, Randwick ☐ Former patient of the Sydney Children's Hospital, Randwick ☐ Parent / Carer of a child / young person the Children's Hospital, Westmead ☐ Former patient of the Children's Hospital, Westmead ☐ Patient, Parent / Carer of other facility

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I have a child / young person with the following condition:	☐ Physical disability ☐ Chronic condition ☐ Mental illness
I have experience with the following:	☐ Short stay event e.g. Emergency Department ☐ Inpatient admission ☐ Outpatients clinics ☐ Diagnostics e.g. pathology, X ray

AFFILIATIONS

Affiliations and memberships *(please list all that you feel might be relevant)*	

EXPERIENCE AND SKILLS

Please provide a brief statement about why you are interested in engaging with The Sydney Children's Hospitals Network. Include a summary of the skills and experience you will bring.	

REFEREE DETAILS

Name of SCHN Employee	
SCHN Facility/Department	
Contact Details	

Please email your completed application form to:
Michelle.Azizi@health.nsw.gov.au by 7 April 2015