



**APPLICATION AND AGREEMENT FORM**

Title (if preferred/used): \_\_\_\_\_ First name: \_\_\_\_\_ Surname: \_\_\_\_\_

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

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

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

Your age (only state if you are comfortable): \_\_\_\_\_

Preferred method of contact:  Phone  Mail  Email

Where did you hear about the Cabrini Community Voice (previously known as the Patient and Family Register)?

Cabrini facility/site  Cabrini website  Cabrini staff member/volunteer

Other (please specify): \_\_\_\_\_

Are you a member of any other community groups? If so please provide details: \_\_\_\_\_

Why would you like to join the Cabrini Community Voice? \_\_\_\_\_

**Consumer representative agreement**

- I agree to be a member of the Cabrini Community Voice for a two-year term.
- I understand that at any time I can choose to vary my participation or be removed from the group.
- I understand that Cabrini may end my role as a consumer representative at any time.
- I understand that I will volunteer my time as a consumer representative but that Cabrini will reimburse me for any reasonable expenses incurred in carrying out my duties (e.g. transport and car parking) if I am required to attend meetings.
- I understand that I am not an employee of Cabrini and will not represent myself as such.
- I will disclose any potential or actual conflicts of interest that may be relevant to my role.
- I understand that my feedback and comments as a consumer representative will be taken into account in relation to Cabrini's plans and services but that my feedback may not always be reflected in final decisions.
- I will comply with all reasonable directions from Cabrini.
- I agree to support Cabrini's mission and to act according to Cabrini's values, as outlined in the 'Our Mission, Values and Vision' booklet, as contained in the information pack for the Cabrini Community Voice.
- I acknowledge that in my role as a consumer representative, I may become aware of private and confidential information. I understand that I must maintain the confidentiality of this information and comply with Cabrini's policies and procedures on privacy and confidentiality, as contained in the information pack for the Cabrini Community Voice.

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

*Consumer representative, Cabrini Community Voice*

**Please return this form to:**

Cabrini Patient Experience team, 183 Wattletree Road, Malvern VIC 3144  
or email [ccv@cabrini.com.au](mailto:ccv@cabrini.com.au)

