Partnering with Consumers Advisory Committee Nomination Form

Name:____________________________________**Date of Birth:** / /

Address: ____

Postal Address:____

Telephone: (B)__________________**(H)**__________________**(M)** __________________

Email Address:____

Why would you like to become a general member of the Partnering with Consumers Advisory committee?
(Please tick as many as apply)

- ☐ I have time available and want to volunteer
- ☐ I want to learn more about Cohuna District Hospital (CDH)
- ☐ I have an interest in the health industry generally
- ☐ I believe that feedback from the community is important
- ☐ I am a regular user of the health service
- ☐ I can represent people who may not usually provide feedback
- ☐ I want to help people give feedback about their experiences at CDH
- ☐ I believe I have valuable skills to contribute to the group

Other:____

____

Please provide details of your special interests and skills:

____

____

____

Please Send Completed Form To:

Community Engagement Officer
Cohuna District Hospital
P. O. Box 317
Cohuna VIC 3568
or fax (03) 54562435 or email communityengagementofficer@cdh.vic.gov.au

If you would like further information or require assistance with this form please telephone Cohuna District Hospital on 5456 5300