Partnering with Consumers 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 committee?
(Please tick as many as apply)

- ☐ I have time available and want to volunteer
- ☐ I want to learn more about Cohuna District Hospital
- ☐ 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:

Quality Manager
Cohuna District Hospital
P. O. Box 317
Cohuna VIC 3568
or fax (03) 54562435 or email *jmoore@cdh.vic.gov.au*
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If you would like further information or require assistance with this form please telephone Cohuna District Hospital on 5456 5300