Consumer Partnership Program – Application form

**Thank you for expressing interest in joining the Consumer Partnership Program at Grampians Health.**

Consumers, are an essential part of the Grampians Health team. Recruitment, support and supervision processes for Consumer Partners are similar to those processes for Grampians Health employees.

Applications are invited from interested persons with a range of skills and experience in one or more of the following areas:

* Active interest in health issues affecting the community
* Strong community links and commitment
* Good communication skills
* People from diverse backgrounds

**Personal Details**

 Title (please tick box): [ ]  Mr [ ]  Mrs [ ]  Ms [ ]  Miss [ ]  Dr [ ]  Mx [ ]  other

|  |  |
| --- | --- |
| First Name:  | Family Name:  |
| Preferred Name:  | D.O.B:  |
| Address: |  |
| Post Code:  | Email:  |
| Phone:  | Mobile:  |

Preferred method of contact: [ ]  Phone Preferred area: [ ]  Grampians Health wide [ ]  Email [ ]  Grampians Health – Ballarat

 [ ]  Grampians Health - Dimboola

 [ ]  Grampians Health – Edenhope

 [ ]  Grampians Health – Horsham

[ ]  Grampians Health – Stawell

To participate in the CPP your details will be stored on the Grampians Health Consumer register. This information will only be used for the purpose of contacting you and linking you to current opportunities at Grampians Health.

**Yes, I agree for my details to be stored securely** [ ]

 **Experience and Qualifications**

Please tell us a little bit about yourself? ***(Please attach a brief resume if you have one):***

Have you had any involvement in our local community and/or consumer groups?

**Yes** [ ]  **No** [ ]

If yes, please describe:

Why would you like to become a member of the Consumer Partnership Program at Grampians Health?

**Referee**

Please supply a name and contact details for 1 referee: (people who know you well enough to comment on your character, not friends or family):

|  |  |
| --- | --- |
| Name:  |  |
| Position / Organisation:  |  |
| Phone No.:  | Email:  |
| Applicant’s signature: | Date: |

**Please return form to the Consumer Partnership Team**

**Grampians Health Quality team**

**Grampians Health**

**PO Box 577**

**BALLARAT VIC 3353**

**Or email**

**GHQuality@bhs.org.au**