

## OUR MISSION

BUILD AND SUSTAIN A COMMUNITY OF  
PATIENT-CENTERED MEDICAL HOMES.

# Advisory Council Expression of Interest

## Join the CWC PCN Patient Advisory Council

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The Calgary West Central Primary Care Network (CWC PCN) is committed to partnering with patients to improve our care. We are currently recruiting patients and family members to join our Patient Advisory Council (PAC) and provide diverse insights into our health services delivery, priorities, and programs. If you are passionate about health care, a CWC PCN patient, and interested in listening to people and providing feedback, we want to hear from you!

Patient advisors start with a two-year term, with the opportunity to renew for a total of six years. To apply, please complete the Patient Advisory Council Expression of Interest form below. The CWC PCN will appoint advisors once the selection process is complete.

This form can be completed electronically or printed and completed by hand. Submission instructions can be found at the end of the application.

If you require assistance with the form or have any questions regarding the Expression of Interest process, please contact our Patient Advisory Council team at [pac@cwpcn.com](mailto:pac@cwpcn.com).

For more information on the Patient Advisory Council, please visit [cwpcn.com/PAC](http://cwpcn.com/PAC).

## About the Calgary West Central Primary Care Network

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The CWC PCN is a team of healthcare professionals that supports you and your community. **More than 507 local doctors are members of the CWC PCN, and we work with them to provide comprehensive, community-based primary care to over 317,532 patients in Calgary.**

Thank you for your interest!

# Patient Advisory Council Expression of Interest Form

Full name: \_\_\_\_\_  
                    (First)                                  (Last)

Are you currently residing in Calgary and the area? ☐ Yes ☐ No

*\*Council members must reside in the Calgary area.*

Primary phone number: \_\_\_\_\_

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

**Please answer the following questions.**

1. What interests you the most about being a patient advisor?

2. What insights, experience and perspectives do you feel you have to offer?

3. Have you previously volunteered with a Patient Advisory Council? ☐ Yes ☐ No

If yes, please indicate location and position:

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4. Are you currently employed with a PCN? ☐ Yes ☐ No

If yes, please indicate location and position:

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5. How did you hear about recruitment for the Patient Advisory Council? Select all that apply.

- ☐ LinkedIn
- ☐ Facebook
- ☐ Instagram
- ☐ Community Newsletter
- ☐ Volunteer Connector
- ☐ Charity Village
- ☐ Volunteer Match
- ☐ Good Work
- ☐ Others (Please specify)

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6. What is your availability? (Meetings will be held weekday evenings at 6 p.m.)

- ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Comments:

Do you consent to the CWC PCN retaining your personal information for the purpose of the Patient Advisory Council? ☐ Yes ☐ No

*Only relevant personal information will be collected and retained. Information collected will only be used for the Patient Advisory Council and will not be shared with third parties without written consent. Personal information will be kept in a secure electronic folder that only CWC PCN staff directly involved with the PAC will have access to. The CWC PCN will provide all necessary measures to ensure information gathered is securely protected.*

Do you consent to CWC PCN running a criminal record check as part of the recruitment process?

☐ Yes ☐ No

Please note that the Patient Advisory Council typically meets virtually every three months, four times per year. The frequency of meetings may change and opportunities to join new projects could arise.

Full name: \_\_\_\_\_  
(First) (Last)

Date: \_\_\_\_\_  
(dd/mm/yy)

Please submit the completed Expression of Interest form via email to: [pac@cwcpn.com](mailto:pac@cwcpn.com)  
with the subject line: **Your Name, Patient Advisory Council Application 2025.**