UNIVERSITY OF ALBERTA

PATIENT IMMERSION EXPERIENCE
UNDERGRADUATE MEDICAL EDUCATION
FACULTY OF MEDICINE & DENTISTRY
1-002 Katz Group Centre for Pharmacy and Health Research
Edmonton, Alberta, Canada T6G 2E1
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Telephone: 780-248-1311, Fax: 780-492-9531

Every patient is a **PERSON WITH A STORY**

Patient Volunteer Application Form

PLEASE DO NOT WRITE DOWN ANY CONFIDENTIAL MEDICAL INFORMATION

_________ ____

TITLE LAST NAME FIRST NAME

Parent Name if participant is a child:____

LAST NAME FIRST NAME

ADDRESS CITY POSTAL CODE

__________________ ____________________________________

AGE DATE OF BIRTH OF PARTICIPANT (optional)

__________________ ________________________ __________________________

HOME PHONE WORK/CELLULAR PHONE EMAIL ADDRESS

________________________________ _____________________________________

EMERGENCY CONTACT NAME EMERGENCY CONTACT PHONE NUMBER

BEST METHOD TO CONTACT YOU (circle): **EMAIL HOME PH. WORK PH. CELL PH. MAIL**

BEST TIME OF DAY TO CONTACT YOU: ____

Number of people in your immediate household____________

NAME:______________________________AGE:______RELATIONSHIP TO YOU:______________________

NAME:______________________________AGE:______RELATIONSHIP TO YOU:______________________

NAME:______________________________AGE:______RELATIONSHIP TO YOU:______________________

NAME:______________________________AGE:______RELATIONSHIP TO YOU:______________________

________________________________ ________________________________

Languages Spoken Place of Birth

Why do you want to be involved as a patient mentor in the Patient Immersion Experience?

How did you hear about the Patient Immersion Experience?

How many times do you visit a doctor in an average year? ____________________________

Please Circle YES or NO to each of the questions below:

1-I am willing to be open and honest about experiences and feelings with my illness/disease/ disorder/syndrome/etc?

YES NO

2-I am comfortable having a pair of medical students come to my home for a series of discussions.

YES NO

3-I am willing to commit to 2 years with the pair of medical students (or about 20 hours total over 2 years, barring extenuating circumstances).

YES NO

4-I see a doctor at least a few times a year for my disease/disorder/syndrome/etc.

YES NO

5-I am comfortable having a pair of medical students accompany me to at least one (1) doctor/clinic appointment.

YES NO

6-I am comfortable with the program administration sending an information letter to inform my physician of the program if need be?

YES NO

Physician's Name________________________________**Clinic**____

Thank you very much for your interest in becoming a patient mentor for our medical students!

____ ________________________________

Signature (or Parent of Child under age 18) Date

PLEASE RETURN COMPLETED APPLICATION FORM TO MELISSA COUMONT BY EMAIL/FAX (above)

or

MAIL TO: Undergraduate Medical Education, 1-002 Katz Group Centre for Pharmacy and Health Research Edmonton, AB, Canada T6G 2E1