



## **Family Advisory Council Application Form**

First Name: .....

Surname: .....

Address: .....

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Email: ..... Phone no: .....

Child's first name: ..... DOB: .....

Surname: .....

Ethnicity: .....

Child Health Services your child has been in contact with:

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Previous Committee Experience (If any): .....

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Availability: ..... (time of day for meeting)

Why do you want to be part of this group?

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For further information or a copy of the Job Description  
please contact Elana Breytenbach on 03 364 0742

Post this application form to Christchurch Hospital, Paediatric Department, Private Bag 4710,  
Christchurch, or in any blue Suggestion Box