Canadian Mental Health Association Kenora
Mental health for all

Association canadienne pour la santé mentale Kenora
La santé mentale pour tous

Client Family Advisory Committee Volunteer Application

NAME:

ADDRESS:

The best way to contact me is by:

Home Phone:
Cell Phone:
Work Phone:
Email:

Canada Post (if address is different from above)

The best time to contact me is:

Morning ☐
Afternoon ☐
Evening ☐
No Preference ☐

I am a (check one)

☐ **Current Client program: ACTT** ☐ **KSH** ☐ **Counselling** ☐ **Court Diversion** ☐ **Case Management** ☐
☐ **Past Client program: ACTT** ☐ **KSH** ☐ **Counselling** ☐ **Court Diversion** ☐ **Case Management** ☐
☐ **Family Member/Caregiver**

Accommodations needed to participate in the Client Family Advisory Committee:

I would like to be part of the Client Family Advisory Committee because:

I am willing to:

YES ☐ **NO** ☐ **Sign a confidentiality form**
YES ☐ **NO** ☐ **Provide or obtain (no charge) a Criminal Reference Check**
YES ☐ **NO** ☐ **Abide by the mission and vision statement of CMHA Kenora Branch**
YES ☐ **NO** ☐ **Abide by the Terms of Reference put forth by the Client Family Advisory Committee**
YES ☐ **NO** ☐ **Sign a committee job description**

Please return completed application to:

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