Community Advisory Council (CAC) Membership Application

Sir Charles Gairdner Osborne Park Health Care Group

Contact details:

Full Name:

Preferred Name:

Preferred Pronouns:
☐ She/Her
☐ He/Him
☐ They/Them
☐ Other (please specify) ________________________

Email:

Phone:

Postcode (of your primary place of residence):

How would you like to be contacted? ☐ Email ☐ Phone call ☐ SMS

About you

CAC membership should reflect the diversity, voices and perspectives of the community we serve. The purpose of collecting this information is to gain a deeper understanding about you and your interests so that we can ensure that a wide range of voices and perspectives in our CAC.

Please note: CAC membership must be drawn from health consumers of Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG). As such, membership is only available to members of the community who have been a consumer of health services at SCGOPHCG in the past 5 years.

Which of the following applies to you?
☐ I have recent experience (in the past 5 years) as a patient at Sir Charles Gairdner Hospital (SCGH) or Osborne Park Hospital (OPH); **and/or,**
☐ I am a carer of a recent consumer of services at SCGH or OPH; **and/or,**
☐ I am a family member of a recent consumer of services at SCGH or OPH.

Which of the following applies to you?

☐ I am a person living with or caring for someone with a disability.
☐ I identify as an Aboriginal and/or Torres Strait Islander person.
☐ I am a member of a cultural or ethnic group or community.
☐ I identify as or am an ally for LGBTQIA+.
☐ I am a person from a non-English speaking background.
☐ None
☐ Other, please describe:

Which Sir Charles Gairdner or Osborne Park Hospital services do you have recent (last 5 years) experience with? (This information is voluntary)

What is your age range?

☐ 16-17 ☐ 18-24 ☐ 25-39 ☐ 40-64 ☐ 65-70 ☐ 75+

Why are you interested in joining a CAC?

Which areas of health or the health system are you interested in?

Are you a member of other consumer groups?
If yes, which ones:

Is there anything else you would like to tell us?

Please let us know if you need any support to enable you to contribute (e.g. Accessibility requirements). (This information is voluntary)

Please return this form to communityadvisorycouncil.scgh@health.wa.gov.au

The information you provide will be kept confidential and will only be used for the purpose of contacting you about this opportunity. This document can be made available in alternative formats on request. *© North Metropolitan Health Service 2025*