**Community Advisory Council (CAC) Membership Application**

## Women and Newborns Health Service (WNHS)

### Contact details

**Full Name:** Click or tap here to enter text.

**Preferred Name:**Click or tap here to enter text.

**Preferred Pronouns:**

She/Her

He/Him

They/Them

Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text.

**Postcode** (of your primary place of residence): Click or tap here to enter text.

**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.

**Which of the following applies to you?**

I have recent experience (in the last 5 years preferred) as a consumer of an NMHS health service.

I am a carer of a recent consumer.

I am a family member of a recent consumer.

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 Click or tap here to enter text.

**Which Women and Newborns Health Services do you have recent (last 5 years) experience with?** This information is voluntary.

Click or tap here to enter text.

**What is your age range?**

16-17

18-24

25-39

40-64

65-70

75+

**Why are you interested in joining a CAC?**

Click or tap here to enter text.

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

Click or tap here to enter text.

**Are you a member of other consumer groups?**

If yes, which ones Click or tap here to enter text.

**Is there anything else you would like to tell us?**

Click or tap here to enter text.

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

Click or tap here to enter text.

**Please return this form by:**

* Email: [WNHSCLS@health.wa.gov.au](mailto:WNHSCLS@health.wa.gov.au)
* Post: Consumer Liasion Service, 15 Loretto Street, Subiaco WA6008

Enquiries to Consumer Liaison Service Manager [WNHSCLS@health.wa.gov.au](mailto:WNHSCLS@health.wa.gov.au) or via phone (08) 6458 1444

*The information you provide will be kept confidential and will only be used for the purpose of contacting you about this opportunity.*