# Patient Partner Appreciation Form

As a valued patient partner of the Alliance, your contributions and time are important to us. Details on the Patient Partner Appreciation Policy and Procedures can be found [here](https://sporevidencealliance.ca/about/policies-procedures/).

To ensure your hours are accurately logged, we kindly ask that you use this tracking sheet to keep a record of all your activities conducted for the Alliance. Please review the Patient Partner Appreciation Policy for more details on the rate, as well as the payment options available to you.

Please submit this form to the Central Coordinating Office ([SPOREA@smh.ca](mailto:SPOREA@smh.ca)) every 3 months so that we can provide you with your preferred payment in a timely manner. All cheques will be mailed to the address provided with your submission. Please be advised that it typically takes 45 days to process your payment, plus additional courier time.

***Thank you for your support and contribution to the SPOR Evidence Alliance. We are truly***

***grateful to have your partnership!***

## Patient Partner Activity Log:

|  |  |
| --- | --- |
| **First and Last Name** |  |
| **Period of Engagement**  *(E.g. January 2019-April 2019)* |  |

**Engagement Record:**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVITY NAME**  *E.g. EC Meeting No. 1* | **DESCRIPTION (optional)**  *E.g. Recurring meeting to discuss business* | **DATE OF ACTIVITY**  *E.g. August 27, 2018* | **NUMBER OF HOURS** |
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| **TOTAL HOURS CONTRIBUTED** | | |  |

**Preferred form of payment:**

I wish to accept payment in the form of cash (cheque) for my total contribution

I wish to accept payment in the form of cash (cheque) and in-kind payment *(please describe in the text box provided)*

I do not wish to receive any form of payment

Other (please *describe in the text box provided)*

**Special requests**

*Please use the text box below to describe any special requests you may have in receiving payment for your contribution.*

|  |
| --- |
| Click or tap here to enter text. |

**Preferred frequency of payment:**

Please process my payment upon receipt of this submission

Please keep my hours logged for now; I will inform you when I wish to receive payment

I do not wish to receive any form of payment

*By signing below you are acknowledging that you completed the work above and agree to receiving recognition in the preferred form of the payment selected above.*

**Privacy & Confidentiality**

Information provided will be strictly used for payment purposes and will be stored securely in the St. Michael’s Hospital network drive. They will be accessible only to the nominated principal investigator, study team and office of research administration at St. Michael’s Hospital.Should there be any breach of privacy, you will be informed right away, but the chance that this information will be accidentally released is judged to be very small.

|  |  |
| --- | --- |
| First and Last Name: | |
| Mailing Address: | |
| Social Insurance Number:  *(Please note this data is needed if you anticipate receiving $500 or more in a given year)* | |
| Phone: | Email: |
| SIGNATURE: | DATE: |