

# VILLA TERENCE

Quality Care and Consumer  
Advisory Committee

## Personal Details

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Please mark the option that best describes you:

Resident

Relative / Representative Resident name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Details:

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Why does being a member of the Quality Care and Consumer Advisory Committee interest you?

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please return this form by placing it in the feedback box at Reception area or email to  
reception@icai.com.au*

## Office use only

Date received: \_\_\_\_\_

Committee membership approved:

Yes

No

Person notified of outcome by: \_\_\_\_\_