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Patient and Family Advisory Council Application

Thank you for your interest in the Patient and Family Advisory Council (PFAC). Membership requires your successful completion of the application and interview process. All of your information will be treated as confidential. Membership on the council requires attendance in the bi-monthly meetings.

Please PRINT all information clearly.

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone number(s): Please indicate preferred phone number and best time to reach you: _____ a.m. p.m.

Work: _____ Home: _____ Cell: _____

E-mail address: _____

Please indicate if you are:

Patient currently receiving treatment/care_____ Prior patient_____ Family member_____

Please answer the following questions:

Why are you interested in being on the PFAC?

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What are some specific things health care professionals did or said that was most helpful to you and your family?

What are some specific things you would like healthcare professionals to do differently in order to be more helpful to you and your family ?

Is there something else you think we should know about you?

To what other community organizations do you belong?

Are you able to make a one-year commitment? Yes _____ No _____

I acknowledge I have provided accurate information to the best of my ability.

Signature: _____ Date: _____

Please allow 2-4 weeks for processing. Applicants will be considered based on the needs of the committee. A confidentiality form will be required to be signed by all PFAC membership.