



Mary Greeley
MEDICAL CENTER

Patient and Family Advisor Application Form

Name (First and Last): _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Home phone: _____ Cell phone: _____ Email address: _____

Preferred contact (circle one): **Home phone** **Cell phone** **Email**

The following questions will help us get to know you better.

1. Are you a...

- Patient
- Family member of a patient
- Neither

2. Have you been a patient in a hospital before? *(Not required to be an advisor.)*

- Yes
- No

3. What language(s) do you speak? _____

5. We recognize that our patient and family advisors have busy lives. How much time are you able to commit to being a patient and family advisor? (Check one)

Less than 1 hour per month

3 to 4 hours per month

1 to 2 hours per month

More than 4 hours per month

6. Are you available to serve as an advisor for at least 1 year?
(You can still be an advisor if you answer "no.")

Yes

No

7. How do you want to help? I want to: (Check all of your interest areas)

Serve as a member of the patient and family advisory council. Potential advisory council members should be ready to commit to serving on the council for at least 1 year. The advisory council meets approximately 6 times per year.

Help develop or review informational materials for patients and family members.

Help improve patient safety.

Help improve the patient and family role in care decision making.

Help improve the hospital facilities (for example, patient care areas or family resource room).

Review procedures and provide input to improve overall hospital processes.

Help educate or train hospital staff and clinicians.

Review procedures and provide input to improve transitions in care (for example, between hospital units or discharge from hospital to home).

Other issues (please describe): _____
