UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Patient Family Advisory Council Membership Application

Name_____

Address_____

City_____

State_____

Zip code_____

Email_____

I am a

Patient _____ Family Member_____

1. At which location did you or a family member receive services

Inpatient	Emergency	Outpatient	Ambulatory	Shore Medical Group
EASTON				
DORCHESTER FMF				
CHESTERTOWN				
QUEEN ANNE				

2. Please tell us about your experience. What went well and what could have been done differently?

_____

_____

3. Why would you like to join our Patient Family Advisory Council?

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_____

4. What area of interest would you like to offer?

_____

_____

5. Are there specific concerns you would like addressed by the Patient Family Advisory Council?_____
_____
_____

6. We believe the Patient Family Advisory Council should reflect the cultural diversity of families who are consumers of our hospital services. Please share anything about yourself that would add to the diversity of our council.

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If selected as a member, you would be committing to one morning meeting per month via web ex.