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 |  |  |  |  |

1. Please tell us about your experience. What went well and what could have been done differently?
2. Why would you like to join our Patient Family Advisory Council?
3. What area of interest would you like to offer?
4. Are there specific concerns you would like addressed by the Patient Family Advisory Council**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. 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.

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