

**FAMILY AND PATIENT
ENGAGEMENT COUNCIL APPLICATION**

Name of applicant(s): _____ Home Phone: _____

Preferred contact person (if applying as a couple): _____

Home Address: _____ Cell/Work Phone(s): _____

City/State/Zip: _____ Best times to reach you: _____

Email(s): _____ Preferred method of contact: _____

Occupation(s): _____ Languages spoken at home: _____

How did you hear about this opportunity? _____

Name of patient or loved one with health needs/experience: _____

Patient's DOB: _____ Patient's Relation to you: _____

Dates of First and Most Recent

Patient's Primary Diagnoses: _____ Admission: _____

Would you be able to participate in monthly meetings for a term of **ONE YEAR**? Yes No

Would you need assistance with transportation, childcare, or other accommodations? Yes No

If yes, please explain:

Patient and Family Engagement Council will take place quarterly (four times per year).

Tell us a little about yourself and your family:

*Why would you like to be a member of the Patient and Family Engagement Council?**

What do you feel you could bring to the Patient and Family Engagement Council?

**Please be aware that the Patient and Family Engagement Council is not a support group. It is a working group to support patient and family-centered care.*

Conditions of Volunteer Services (Please read before signing):

We will contact you by phone or e-mail if you are selected for an on-site interview to learn more about your interests, and discuss the opportunity to become a member of the Patient and Family Engagement Council. In order to participate, you must meet our routine volunteer requirements. You will be required to pass a criminal background check, submit immunization records and receive any necessary immunizations, undergo HIPAA training and sign a confidentiality agreement. If you are unable to fulfill these requirements, you will not be eligible to serve on the Patient and Family Engagement Council.

I certify that the statements made in this application are true and correct and have been given voluntarily. I understand that I will not be paid for my services as a volunteer member of the Patient and Family Engagement Council. I agree to abide by the guidelines of Volunteer Services, to respect patient confidentiality, and to uphold the standards of Hospital Sisters Health System. All information contained on this form is considered confidential and is intended for use by the HSHS Patient and Family Engagement Council Selection Committee only.

Applicant's Signature: _____

Date: _____

Please return completed application to:

HSHS St. Joseph's Hospital Highland
HSHS Patient and Family Engagement Council
Attention: Shannon Luitjohan
12866 Troxler Ave
Highland, IL 62249
P: 618-651-2530
Email: Shannon.Luitjohan@hshs.org