HSHS St. Elizabeth's Hospital

PATIENT AND FAMILY ADVISORY COUNCIL APPLICATION

Name of applicant: *Home Phone:*

Home Address: *City/State/Zip:*

Cell/Work Phone(s): *Best times to reach you:*

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

Occupation(s):

Have you been employed by any HSHS entity? If yes, when?

How did you hear about this opportunity?

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

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

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

HSHS St. Elizabeth's Hospital

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Which HSHS St. Elizabeth's Hospital service has you or your family used? Please check all that apply below. Check "Past Year" if you have used the service within the past year or "Ever Received", if you have ever used the service in the past.

Myself or a family member has received health care services at the following HSHS Hospital (check below):

☐ ***HSHS St. Elizabeth's Hospital (current O'Fallon location)***
☐ ***HSHS St. Elizabeth's Hospital (former Belleville location)***

Past Year	*Ever Received*	*Services*
☐	☐	CARDIAC REHAB
☐	☐	CARDIOVASCULAR-PRAIRIE CARDIOVASCULAR
☐	☐	CATH LAB
☐	☐	CT
☐	☐	EEG
☐	☐	EMERGENCY
☐	☐	ENDOSCOPY
☐	☐	HEMODIALYSIS
☐	☐	INTENSIVE CARE UNIT (ICU)
☐	☐	INFUSION THERAPY
☐	☐	INTERVENTIONAL RADIOLOGY
☐	☐	LAB
☐	☐	MED/SURG
☐	☐	MRI
☐	☐	NUCLEAR MEDICINE
☐	☐	PAIN MANAGEMENT
☐	☐	PATHOLOGY
☐	☐	TELEMETRY, UNIT A
☐	☐	TELEMETRY, UNIT B
☐	☐	RADIOLOGY
☐	☐	REHAB UNIT
☐	☐	RESPIRATORY SERVICES
☐	☐	SLEEP DISORDERS CENTER
☐	☐	SURGERY - INPATIENT
☐	☐	SURGERY - OUTPATIENT
☐	☐	THERAPY - INPATIENT (PHYSICAL, OCCUPATIONAL, SPEECH, AUDIOLOGY)
☐	☐	THERAPY - OUTPATIENT (PHYSICAL, OCCUPATIONAL, SPEECH, AUDIOLOGY)
☐	☐	ULTRASOUND
☐	☐	URGICARE
☐	☐	VASCULAR LAB
☐	☐	WOMEN AND INFANTS CENTER
☐	☐	WOMEN'S IMAGING
☐	☐	WOUND CARE

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Tell us a little about yourself and your family:

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

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

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Conditions of Volunteer Services (Please read before signing):

We will contact you by phone or e-mail if you are selected for a phone interview to learn more about your interests, and discuss the opportunity to become a member of the Patient and Family Advisory 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 Advisory 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 Advisory Council Selection Committee only.

Applicant's Signature: *Date:*

Please return completed application by mail or email to:
Amber Badolato, Patient Experience
HSHS St. Elizabeth's Hospital
1 St. Elizabeth's Blvd.
O'Fallon, IL 62220618-234-2120

STEAdvisoryCouncil@hshs.org