HSHS St. Joseph's Hospital | Breese

PATIENT AND FAMILY ADVISORY COUNCIL APPLICATION

Name of Applicant _____ Phone Number _____

Address _____

City/State/Zip _____

Email _____

Primary Language _____ Occupation _____

How did you hear about this opportunity? _____

Would you be able to participate in quarterly meetings for a minimum of 1 year? ☐ Yes ☐ No

Any personal or patient experiences that you would like to share or discuss?

_____

Print Name _____

Signature _____

Date _____

Patient and Family Advisory Council will take place quarterly (four times per year) with the first meeting to be held _____

HSHS St. Joseph's Hospital | Breese

Conditions of Volunteer Services (Please read before signing)

You will be contacted by phone or e-mail if you are selected for an interview. Interviews may be on-site or virtual. The goal of the interview is to learn more about your interests and discuss the opportunity to become a member of the Patient and Family Advisory Council. 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 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 Advisory 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 in this form is considered confidential and is intended for use by the HSHS Patient and Family Advisory Council Selection Committee only.

Applicant's Name (Printed) _____

Applicant's Signature _____

Date: _____

Please save this completed application document and submit it along with a resume and referrer (if applicable) to:

PFACSJB.applications@hshs.org

HSHS St. Joseph's Hospital | Breese

Patient and Family Advisory Council (PFAC)

Application

Tell us a little about yourself and your family:

Why would you like to be a member of the PFAC?

What do you feel you could bring to the PFAC?

Please be aware that the PFAC is not a support group. It is a working group to support patient and family-centered care