patient and family advisory council membership application

NAME:____

MAILING ADDRESS: ____________________________________

CITY: ____________________ STATE: ________ ZIP: ____________________

HOME PHONE: ____________________ WORK PHONE:____________________

E-MAIL ADDRESS: ____________________________________

1) HAVE YOU OR A FAMILY MEMBER RECEIVED CARE AT SVMC WITHIN THE PAST YEAR? ☐ YES ☐ NO

AREA(S) CARE WAS RECEIVED:

☐ INPATIENT ☐ OUTPATIENT ☐ EMERGENCY ROOM ☐ URGENT CARE ☐ OTHER

☐ AMBULATORY SURGURY ☐ FAMILY HEALTH CENTER

2) WHY WOULD YOU LIKE TO BE A MEMBER OF THE PATIENT AND FAMILY ADVISORY COUNCIL?

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3) WHAT AREA(S) OF CONCERN DO YOU HAVE THAT YOU WOULD LIKE TO OFFER THE COUNCIL?

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4) WHAT SPECIAL INTERESTS OR EXPERIENCES WOULD YOU LIKE TO OFFER THE COUNCIL?

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5) WE BELIEVE THE PATIENT AND FAMILY ADVISORY COUNCIL SHOULD REFLECT THE DIVERSITY OF THE POPULATION THAT SVMC SERVES. IN LIGHT OF THIS, PLEASE SHARE ANYTHING ABOUT YOURSELF YOU THINK WOULD ADD TO THE DIVERSITY OF OUR COUNCIL.

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Please return this completed application to:
The Patient Relations Department at St. Vincent's Medical Center
2800 Main Street, Bridgeport, CT 06606