YOUR ORGANIZATION NAME

Patient & Family Advisor Application

Would you be a partner with us to deliver patient- and family-centered care every time in every encounter? To reach this goal, we need your ideas, feedback and participation as together we improve the experience of care for our patients and families. We are seeking individuals for a variety of opportunities – both short term and ongoing.

Date: _____

Name: _____
Last First MI

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____

What is the best way to contact you? (circle one) **Home Work Cell Email**

Please check all that apply below:

☐ I am a patient at a name of hospital/clinic or facility
→If yes, from which location(s) do you receive services? _____

☐ I am the family member of a patient from : _____

☐ I am a patient with a chronic health condition (e.g., diabetes, heart failure, asthma, depression, arthritis)

☐ I am involved in the care of someone who has a chronic health condition

☐ I am a patient/family member receiving preventative and/or occasional illness care

SKILLS & INTERESTS If you wish to provide more information, please use the space below to describe any special training, interests, hobbies or experiences you feel could be valuable to your work as a Patient/Family Advisor with us.

_____

_____

_____

_____

Please indicate the ways in which you would like to participate as a Patient/Family Advisor:

___ Phone Interview: Share your opinion and respond to survey questions over the telephone.

___ Focus Group: Provide feedback in a group format with other patients/family members.

___ Participate on Committees: Bring the patient/family voice/experience to committee meetings.

___ Story Sharing: Share your health care experiences with care providers and other patients.

___ Be a partner in making improvements to specific health care services.

___ Be a member of a Patient Family Advisory Council (monthly evening meetings)

___I don't know yet, I need more information.

Please put an 'X' in the Day(s) and Time(s) you are available to meet for an interview and/or informational session:

	Monday	Tuesday	Wednesday	Thursday	Friday
Mornings					
Afternoons					
Evenings					

Your responses are important in planning your involvement with us. If you have questions concerning the program or this application, please call NAME OF LIAISON, E-MAIL AND PHONE NUMBER.

Please return your completed application using the return envelope enclosed.

Adapted from Participating Clinics in the Quality Corporation's Patient and Family as Leaders Program in Oregon