Patient & Family Advisory Council
APPLICATION

Thank you for your interest in the Patient & Family Advisory Council. Patient and family feedback is the best way for us to know how we are doing and to continue the development of care and services to better meet the needs of the community.

Please complete this brief application in its entirety. Selected applicants will be contacted to schedule a phone interview. Patient and Family advisors will be considered volunteers of Community Medical Centers (CMC) and must agree to all volunteer requirements.

If you have any questions, please call (559) 324-4742 or email PFAC@communitymedical.org.

Applicant Information

Last Name _____ First_____ M.I. _____

Address _____

City _____ State _____ Zip Code _____

Day Phone (_____) _____ - _____ Mobile (_____) _____ - _____

Email Address_____

Best way to reach you: ☐ Day Phone ☐ Mobile Phone ☐ Email ☐ Postal Mail

Age: ☐ 18-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71 or greater

We are hoping to find advisors that reflect the diverse experiences of patients and families who use our hospitals. Please answer the follow questions regarding your experience at CMC.

I am or have been: ☐ A patient ☐ A family member of a patient(s) *

☐ Both patient & family member * Relationship to patient(s) _____

☐ **What facility did you/family member receive care?** _____

Within the past 12 months, where have you or your family member(s) been treated?
(*Check all that apply)*

☐ Inpatient Units (ICU, Med/Surg, Telemetry) ☐ Woman and Infants ☐ Pediatrics

☐ Outpatient Services (Ex: Surgery, Radiology, P.T.) ☐ Cancer Institute ☐ Emergency

☐ Other _____

Last Name _____ First _____ M.I. _____

Please tell us why you are interested in serving as a patient/family advisor and why you feel you would be a good representative for other patients/families.

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Please describe any other committee experience you have had either in the community, schools, churches, etc.?

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Are you comfortable speaking in front of other people, either presenting information or sharing personal experiences?

☐ Yes ☐ No If no, please explain _____

Would you be able to make a commitment of at least one year (renewable up to three years)?

☐ Yes ☐ No If no, how long could you commit? _____

APPLICANT ACKNOWLEDGEMENT & SIGNATURE

By typing my name below, I sign this document and acknowledge that I have provided accurate information to the best of my ability.

Signature _____ Date _____

Send completed application to PFAC@communitymedical.org or fax to 559.324.3744