Patient & Family Advisory Council Application Form

Please complete and submit this form if you are interested in serving on the Patient and Family Advisory Council (PFAC) as an advisor. The PFAC will provide WCHC leadership and Board of Directors with suggestions and constructive feedback on a variety of patient and family issues concerning patient care at WCHC. Patient/family advisors will provide their perspective on how we serve patients and their families. Topics may be introduced by WCHC staff members, as well as Council members. WCHC will select a limited number of applicants and will be choosing a cross-section of demographics to mirror our current patient population. If you are not selected at this time, we will keep your application on file when future opportunities may become available.

The PFAC will meet as a group at least four times each year with various WCHC staff. All meetings will be held at WCHC's Conowingo office. Patient and Family Advisors will serve a two-year term.

Date _____

Name _____

Address _____

_____

Phone _____ **Text Message OK?** _____

Email Address _____

Circle Preferred Contact Method: Phone Email **Best Time to Reach You?** _____

Age: ☐ 20-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61- 70 ☐ 71 or older

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Other Pacific Islander ☐ More than One Race. ☐ Unreported/Declined to Report

Ethnicity: ☐ Non-Hispanic/Latino. ☐ Hispanic/Latino. ☐ Unreported/Declined to Report

Gender: ☐ Male. ☐ Female ☐ Unreported/Declined to Report. ☐ Other: _____

Highest Level of Education:

☐ Some High School but did not graduate
☐ High School Graduate or GED ☐
Some college or 2-year degree
☐ 4-Year College Graduate
☐ More than 4-year college degree

Occupation/Job Title _____

Languages Spoken: ☐ English ☐ Spanish ☐ Other _____

Have you ever been part of a council or leadership group before? ☐ Yes ☐ No

If yes, please describe this experience and/or your role with that group

Have you been a patient at WCHC in the last 2 years? ☐ Yes ☐ No

Has a friend or family member been a patient at WCHC in the last 2 years? ☐ Yes ☐ No

Please tell us about your experience(s) at WCHC. What did we do well?

What could we have done better?

Why do you want to be a member of WCHC's PFAC?

Are there certain topics or issues you would like to see addressed by the PFAC?

How did you hear about WCHC's PFAC?

Conditions of Volunteer Services: (Please read before signing):

We will contact you by phone or email if you are selected for an on-site 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 volunteer requirements. You will be required to pass a criminal background check, undergo HIPAA training and sign a confidentially agreement. Meetings will be held quarterly with specific meeting times determined by the PFAC members. 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 Advisory Council. I agree to abide by the guidelines of Volunteer Services, to respect patient confidentiality, and to uphold the standards of WCHC. All information contained on this form is considered confidential and is intended for use only by WCHC.

Applicant's Signature: _____ **Date**: _____

Thank you for your interest in WCHC's Patient and Family Advisory Council.

If you have any questions regarding PFAC or to return your application:

Email – PFAC@westcecilhealth.org
Mail – WCHC
Attention: PFAC
P.O. Box 99
Conowingo, MD 21918