St.JosephHealth Mission Hospital

APPLICATION FOR PATIENT AND FAMILY ADVISORS

Name: _____ **Date:** _____

Address: _____

Preferred Phone: _____ **Email Address:** _____

Languages Spoken: _____

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:

_____

_____

At which campus was Care received: ☐ Mission Hospital – Mission Viejo ☐ Mission Hospital – Laguna Beach

I am/was: ☐ A patient ☐ A family member of a patient

My care is/was provided by _____ **Check all that apply:**
(Department)

☐ Hospitalization (inpatient) ☐ Emergency Department

☐ Clinic visit (outpatient) ☐ Surgical Services

☐ Other programs, departments, or services (Please list)

_____

The dates of my active care experience include:

☐ Within the last 12 months ☐ 2 – 3 years ago

☐ 4 – 5 years ago ☐ More than 5 years ago

I would be interested in helping with (identify all your areas of interest):

☐ Developing/reviewing educational materials to improve the patient and family experience.

☐ Participating as a member of regular hospital committees or councils to provide the patient and family perspective.

☐ Participating in task groups working to make improvements in systems or processes impacting the care experience.

☐ Educating new employees and/or other staff about the experience of care and effective communication support.

☐ Serving in an executive function on the Patient Family Advisory Council.

Please share why you would like to be a member of the Mission Hospital Patient Family Advisory Council?

_____

_____

_____

Please tell us about your or your family member's healthcare experience at Mission Hospital. What would you have improved about this experience?

What has been impressive about your experience at Mission Hospital?

Please describe the topics or issues you would like to see addressed by the Patient Family Advisory Council?

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, submit immunization records and receive any necessary immunizations, undergo HIPAA training and sign a confidentially agreement. 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, bylaws, and charter of the Patient Family Advisory Council, to respect patient confidentiality, and to uphold the standards of Mission Hospital. All information contained on this form is considered confidential and is intended for use only by Mission Hospital.

First Name	**Last Name**	**Signature**	**Date**

Thank you for your interest in Patient Family Advisory Councils at Mission Hospital.

If you have any questions regarding Patient Family Advisory Councils or to submit your application:

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Mail – Mission Hospital
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