patient and family advisory board 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 BOARD?

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

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

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5) WE BELIEVE THE PATIENT AND FAMILY ADVISORY BOARD 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 BOARD.

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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