# 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*

Included in Minniti, M. M., & Abraham, M. R. (2013). *Essential Allies—Patient, Resident, and Family Advisors: A Guide for Staff Liaisons.* Bethesda, MD: IPFCC.