Patient and Family Advisory Program (PFAP) – Application

Thank you for your interest in the Patient & Family Advisory Program (PFAP). The PFAP was established as a participatory and collaborative effort of patients, families, care providers, hospital staff and management leaders to promote improvement in quality of care, continuity of care, patient experience and overall patient satisfaction. Participation requires completion of the membership application and a 6 month commitment with attendance at regularly monthly and biannual meetings as scheduled. Meetings will be scheduled for a recurring date/time for majority attendance and team member flexibility is greatly appreciated.

Applicant Information - All of your information will remain confidential.

Last Name: _____ First: _____ MRN# _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Email Address:_____

We are hoping to recruit members that reflect the diverse experiences of patients and families at our hospital. Please answer the follow questions regarding your experience(s) at VMC.

Please indicate with a check mark which applies to you:

□ Currently receiving services
□ Past recipient of services
□ Family member of current patient
□ Family member of past patient
□ Care Giver - friend or significant other
□ Care Giver - volunteer

How did you hear about the Patient-Family Advisory Team?

_____

_____

_____

Please tell us why you are interested in serving as a Patient-Family Advisor Team member and why you feel you would be a good representative for other patients/families.

_____

_____

_____

Please describe any volunteer or advisory experience you have had either in the community, schools, hospitals, churches, etc.?

_____

_____

_____

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

☐Yes ☐ No If no, please explain _____

Applicant Acknowledgement & Signature

- I certify that the information given in this application is true and correct and given voluntarily.
- I agree to comply with the HIPAA guidelines and volunteer policies of Valley Medical Center.
- I understand that some information I may gain, directly or indirectly, concerning a patient, physician or any other person may be sensitive in nature and that is to be kept confidential.
- I authorize the staff of the PFAP to discuss my participation on the Team with appropriate staff, if applicable.
- I understand and agree to comply with appropriate use of the picture badge provided to me and will only use and wear the badge for membership identification during meetings and other PFAP related events.

Applicant's Signature: _____ Date: _____

For those applying as a family member: To assure compliance with Federal HIPAA regulations, family members must include patient's name and obtain his/her signature to indicate that he/she understands you may use his/her name and or medical history in your capacity as an advisory member.

Patient Name: _____ Patient Signature: _____ Date: _____

Customer Service Department - Attn: Patient & Family Advisory Program
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