Samaritan North Lincoln Hospital and Clinics'
Patient Advisory Council

Today's Date :_____

Patient and Family Advisory Council Membership Application

Your Name (Please Print): _____

Home Address: _____

Daytime Phone: (_____) _____-_____ Best Day/Time to Call: _____

Email Address: _____

I am a (Please Select One):_____ Patient _____Family Member

Tell us about yourself :

1. While your personal opinion is of great value, your role on the team would be to represent the needs of all patients. Do you feel that you can do this? _____
_____
_____

2. Describe a time when you've been involved in a situation where someone had an opinion different than yours. How did you handle that situation? _____
_____
_____
_____
_____

4. Why do you want to volunteer to be involved in the Patient and Family Advisory Council; do you have any health care experiences that you would bring to the group?
_____
_____
_____
_____

5. Can you devote up to 2 hours per month to the group? (Meetings, Reading, Discussions, and Follow-Up Research) _____
_____
_____
_____

Any additional information:
_____
_____

Thank you for taking the time to complete this application. Please return this completed form to SNLH Quality Resources Department.

What happens next?

When we receive your application, we will contact you to set up a time to speak together. Hospital Leadership along with select staff members will choose the Council Members. The full process will take several weeks. You will be notified by telephone as to whether or not you have been selected for the Council. Before participating in the Council, you will be asked to sign a confidentially statement and an Agreement to Serve.

Official Use Only: Reviewed _____(date)