Samaritan
Pacific Health Services
Building healthier communities, together

Patient-Family Advisory Council (PFAC)

Application

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ Cell Phone: (____) _____

Fax Number: (____) _____ Email Address: _____

Will you allow your contact information to be shared with other council members?

☐ Yes ☐ No

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

Program/Department and Services involved in your care (Your care was primarily):

☐ Inpatient ☐ Outpatient ☐ Both inpatient and outpatient ☐ Emergency Care

☐ Clinics ☐ Other Programs, departments, or services: (explain)

Why would you like to serve as an advisor?

If you have served as an advisor, been an active volunteer committee member, or done public speaking for other programs/organizations, please briefly describe this experience:

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What are some specific things that health care professionals have done or said that was most helpful to you and your family?

What are some specific things that you and your family would like health care professionals to do *differently* to be more helpful?

Please put an "X" in the Day (s) and Time (s) you are available to meet for an interview:

	Monday	Tuesday	Wednesday	Thursday	Friday
Mornings					
Afternoons					
Evenings					

I can commit to: ☐ 1 Year ☐ 2 Years ☐ Other _____

What would make it easier for you to attend PFAC meetings?

Stipends are available should you need reimbursement for:

- Travel
- Childcare
- Other