Patient and Family Advisor Application

--PLEASE PRINT--

NAME: _____

First *MI* *Last*

If youth, Date of Birth: _____

If youth, School: _____

If youth, Grade: _____

Who referred you to us? _____

What is your relationship to the hospital? (check all that apply)

- ☐ Patient
- ☐ Staff
- ☐ Patient family
- ☐ Volunteer
- ☐ Physician
- ☐ Other _____

Address: _____

City: _____

State: _____ Zip code: _____

Phone 1: _____ ☐ cell ☐ work ☐ home

Phone 2: _____ ☐ cell ☐ work ☐ home

Phone 3: _____ ☐ cell ☐ work ☐ home

Email 1: _____

Email 2: _____

Occupation: _____

Special needs request:

_____

_____

_____

Availability: (check all that apply)

- ☐ Anytime
- ☐ Saturday
- ☐ Day
- ☐ Sunday
- ☐ Night

Which Advisory Council are you interested in serving on?

- ☐ Joe DiMaggio Family
- ☐ Joe DiMaggio Youth
- ☐ Memorial Cancer Center
- ☐ Memorial Miramar
- ☐ Memorial Pembroke
- ☐ Memorial West
- ☐ Memorial Regional
- ☐ Memorial South
- ☐ Outpatient Satisfaction
- ☐ Primary Care Clinic
- ☐ Special Needs

Application date: _____