APPLICATION FOR PATIENT AND FAMILY ADVISORY COUNCIL

Please Print:

Name: _____
(Last) (First) (MI)

Address: _____
(Street Address, City, State, Zip Code)

Home Phone: (10 digits) _____ **Cell Phone:** (10 digits) _____

E-mail Address: _____

Emergency Contact name and phone: _____

Language(s) You Speak: _____

Will you allow your contact information to be shared with other advisory council members? Yes / No

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

My care is/was provided by: _____: (check all that apply)
(Department/Doctor)

☐ Hospitalization (inpatient) ☐ Emergency Room (ER) ☐ Clinic visit (outpatient)
☐ Both inpatient and outpatient ☐ Other programs, departments, or services

The year of my care experience at Memorial Hospital include: (check all that apply)
☐ 2016 ☐ 2015 ☐ 2014 ☐ 3 years ago or more

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 or organizations, please briefly describe this experience:

Do you know other individuals and/or families who have experienced care at Memorial Hospital who might be interested in serving as advisors? Please call them for us or list their name(s) and phone number(s) here:

Please return this form to:
Volunteer Services
1400 E. Boulder St., Colorado Springs, CO 80909

Or scan form and email to: Volunteer.Services@uchealth.org