GOODLAND REGIONAL MEDICAL CENTER

Voices In Partnership

A Patient and Family Advisory Council

APPLICATION FOR VOICES IN PARTNERSHIP

Name:_____

Mailing Address: _____

City: _____ ZIP Code: _____

Email: _____

Telephone Home: _____Cell: _____

1) Would you like to be on the council?

____ Yes ____ No

If No: Would you be interested in serving in the future? If so, please fill out the contact information and return to us in the self-addressed, stamped envelope.

2) What is your preferred way of receiving communication about the council?

____ Email ____ Pick up within 3 days of a meeting

3) Is it okay to share your contact information (address, telephone number, email address) with other members of the council?

____ Yes ____ No

4) What issues would you like to see the council address?

_____

_____

_____

_____

(Over)

5) What special interest or experiences would you be able to offer to the council? (I.e. career history, work experiences, previous council experience)

_____

_____

6) Do you have any dietary needs we should be aware of (e.g. allergies, vegetarian)?

____ Yes ____ No

If yes, please explain: _____

7) Do you have any special needs we should be aware of?

____ Yes ____ No

If yes, please elaborate: _____

8) What would be the best day and time to schedule meetings?_____

_____

Member of the VIP council must adhere to all HIPAA regulations to protect patient privacy.

Signature: _____ Date: _____