Patient & Family Advisory Council Application Form

Please complete and submit this form if you are interested in serving on the Patient and Family Advisory Council (PFAC) as an advisor. The PFAC will promote and support patient- and family-centered care at Saunders Medical Center. The PFAC strives to promote respectful, effective partnerships among patients, families and healthcare professionals in the community.

The PFAC will meet approximately 4 times each year. Patient and Family Advisors will be expected to attend all meetings and will be comprised of SMC staff, patients, and families of patients. A member of the council may resign at any time by submitting a written notification to the Director of Quality Services.

Date:_____

Name: _____

Address: _____

Preferred Phone:_____

E-mail Address:_____

Preferred Contact Method: □ Phone □ E-mail Best Time to Reach You:_____

Age: □ 20-30 □ 31-40 □ 41-50 □ 51-60 □ 61-70 □ 71 or older

Highest Level of Education:

- □ Some High School but did not Graduate
- □ High School Graduate or GED
- □ Some College or 2-year Degree
- □ 4-Year College Graduate
- □ More than 4-year College Degree

Occupation/Job Title: _____

Languages Spoken: □ English □ Spanish □ Other _____

Have you ever been part of a council or leadership group before? □ Yes □ No

If yes, please describe this experience and/or your role with that group.

_____

_____

Are you a patient at Saunders Medical Center? □ Yes □ No

Has a friend or family member been a patient at Saunders Medical Center in the past year?
□ Yes □ No

Please tell us about your experience(s) at Saunders Medical Center

_____

_____

_____

_____

What did we do well?

_____

_____

_____

_____

What could we have done better?

_____

_____

_____

_____

Why do you want to be a member of Saunders Medical Center's Patient and Family Advisory Council?

_____

_____

_____

_____

Are there certain topics or issues you would like to see addressed by the PFAC?

_____

_____

_____

_____

How did you hear about Saunders Medical Center's Patient and Family Advisory Council (PFAC)?

_____

_____

Conditions of Volunteer Services: (Please read before signing):

We will contact you by phone or e-mail if you are selected to participate in the PFAC at Saunders Medical Center.

In order to participate, you must meet our volunteer requirements. You will be required to pass a criminal background check, submit immunization records and receive any necessary immunizations, undergo Health Insurance Portability and Accountability Act (HIPAA) training and sign a confidentiality agreement. If you are unable to fulfill these requirements, you will not be eligible to serve on the Patient and Family Advisory Council.

I certify that the statements made in this application are true and correct and have been given voluntarily. I understand that I will not be paid for my services as a volunteer member of the Patient and Family Advisory Council. I agree to abide by the Guidelines of Volunteer Services, to respect patient confidentiality, and to uphold the standards of Saunders Medical Center. All information contained on this form is considered confidential and is intended for use only by Saunders Medical Center.

Applicant's Signature:_____ Date:_____

Thank you for your interest in Saunders Medical Center's Patient and Family Advisory Council.

If you have any questions regarding PFAC or to return your application:

Email: dsabatka@smcne.com
Mail: Attention: Director of Quality Services
Saunders Medical Center
1760 County Road J
Wahoo, NE 68066

Saunders MEDICAL CENTER