UNION HOSPITAL

**Patient & Family Centered Care**
**Advisor Application**

Today's Date _____

Name *(Please Print)*_____

Home Address _____

City_____ State_____ Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____

Work Phone (_____)_____ Is it ok to call you at work? ☐ Yes ☐ No

Number to call first: ☐ Home ☐ Cell ☐ work Email Address _____

Profession:_____ Are you over the age of 18? ☐ Yes ☐ No

**How did you hear about the Patient & Family Centered Care Program?**

☐ Family/Friend ☐ Website ☐ Facebook ☐ Newsletter ☐ Newspaper

☐ Patient Handbook ☐ Hospital employee *(name)* _____

☐ Other (list) _____

**Reference**

Please give the name of a personal or professional reference that we may contact.

Name_____ Phone Number_____

I understand that:

- I will be required to participate in an interview process for selection
- If selected, I am making a three-year commitment to participate as an Advisor
- My health care will not be affected by my participation
- I understand that there are a limited number of opportunities and I may not be selected

_____ _____
Signature Date

Thank you for your interest in the Patient & Family Centered Advisor Program. If you have any questions or need additional information, please contact the Public Relations Office at 410-392-7002 or kmckinney@uhcc.com.

Please return forms to: Public Relations Office
Patient & Family Centered Advisor Program
Union Hospital
106 Bow Street, Elkton, Maryland 21921



Updated 3/2013

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**Please tell us about yourself.**

To be eligible to serve as a Patient & Family Centered Advisor, you or a family member must have been treated at Union Hospital as either an inpatient or received outpatient care.

How are you related to the patient(s) listed below? ☐ Self ☐ Parent ☐ Other ____

| | **Patient's Name** *First* *Last* | **Patient has been cared for at Union:** In the last 3 years? | Times per year |
|---|---|---|---|
| **1** | | ☐ Yes ☐ No | ☐ 1-2 ☐ 3-5 ☐ > 6 |
| **2** | | ☐ Yes ☐ No | ☐ 1-2 ☐ 3-5 ☐ > 6 |
| **3** | | ☐ Yes ☐ No | ☐ 1-2 ☐ 3-5 ☐ > 6 |
| **4** | | ☐ Yes ☐ No | ☐ 1-2 ☐ 3-5 ☐ > 6 |
| **5** | | ☐ Yes ☐ No | ☐ 1-2 ☐ 3-5 ☐ > 6 |

**Where have you or your family member been cared for** (please check all that apply)

- ☐ Emergency Department
- ☐ Same Day Surgery
- ☐ X-ray (MRI, CT Scan, Ultrasound, etc.)
- ☐ Lab
- ☐ Wound Care Center
- ☐ Diabetes Center
- ☐ Breast Health Center
- ☐ Sleep Disorders Center
- ☐ Infusion Center

Inpatient Units (patient stayed overnight, please check all that apply)

- ☐ Maternal & Infant Center
- ☐ 2 South/Pediatrics
- ☐ Medical Specialty Unit at 2 East
- ☐ Intensive Care/Progressive Care Unit at 3 East
- ☐ Surgical Specialty Unit at 3 South
- ☐ Observation Unit at 3 North

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**Why do you want to be a Patient & Family Centered Care Advisor?** (please use other side of page if you need more space)