



**Patient & Family Centered Care
Advisory Council 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 _____

Are you over the age of 18? Yes No

How did you hear about the Patient & Family Centered Care Advisory Council?

- 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 committee selection
- If selected, I am making a three-year commitment to participate on the Advisory Council
- My health care will not be affected by my participation
- I understand that there are a limited number of spots on the Advisory Council and I may not be selected

Signature

Date

Thank you for your interest in the Patient & Family Centered Advisory Council. 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 Advisory Council
Union Hospital
106 Bow Street, Elkton, Maryland 21921



Please tell us about yourself.

To be eligible to serve on the Patient & Family Centered Advisory Council, 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 <i>First</i> <i>Last</i>	Patient has been cared for at Union:	
		In the last 3 years?	Times per year
1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> > 6
2		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> > 6
3		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> > 6
4		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> > 6
5		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> > 6

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

- | | |
|---|---|
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Diabetes Center |
| <input type="checkbox"/> Same Day Surgery | <input type="checkbox"/> Breast Health Center |
| <input type="checkbox"/> X-ray (MRI, CT Scan, Ultrasound, etc.) | <input type="checkbox"/> Sleep Disorders Center |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Infusion Center |
| <input type="checkbox"/> Wound Care Center | |

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

- Maternal & Infant Center
- 2 South/Pediatrics
- Intensive Care Unit
- Progressive Care Unit
- Medical/Surgical Unit (2 East or 3 East)

