DOWNSTATE
HEALTH SCIENCES UNIVERSITY

Patient and Family Advisory Committee
Membership Application

A. Applicant Information

Applicant's Name: ____

Applicant is a: ☐ Patient ☐ Caregiver/Family Member/Partner

Length of time applicant has been a patient/caregiver at UHD? ________ Years ________ Months

Gender: ___________________________________ Birth Year (YYYY): ____________________

Why are you interested in participating in the Patient and Family Advisory Committee?

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Mark all statements that best describe you

- ☐ A patient that receives preventive care and occasional illness care
- ☐ A caregiver for a patient that primarily receives preventive care and occasional illness care
- ☐ A patient that has a chronic health condition
- ☐ A caregiver for a patient with a chronic health condition

B. Contact Information

Cell Phone: __________________________________ Address: _____________________________Apt#______

Email : ____ City//State/Zip: __________________________________

C. Applicant Membership Eligibility Criteria

• Attend meetings every other month	• Work toward positive outcomes
• Willingness to learn about healthcare improvement	• Willing to provide feedback from community
• Patient or family member of a patient	• Willing to follow a confidentiality agreement
• Collaborate with diverse individuals in a group setting	• Empathetic, ethical, strong, and positive character
• Willing to ask and answer questions from the patient's perspective	
****No Conflict of Interest with healthcare facility/industry or work of the committee. No spouses or relatives of employees.*	

Signature ____**Date**_______________

Please complete and email form to PFAC@downstate.edu
Call Patient Relations Department with any questions 718-270-1111

Thank you

Patient and Family Advisory Committee