



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?

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	
<i>***No Conflict of Interest with healthcare facility/industry or work of the committee. No spouses or relatives of employees.</i>	

Applicant or Referring Individual: _____ 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