# Patient Family Advisory Council (PFAC) Member Application

1. Please fill out the prompts below for consideration:

| | |
|---|---|
| First Name | |
| Last Name | |
| Phone Number | |
| Email | |
| Mailing Address | |

2. Which option below best describes your interest in becoming a member of the PFAC?

- ☐ Improvement of overall care experience for patients and their families
- ☐ Improvement of safe patient care practices
- ☐ Process improvement to assist in expediting care
- ☐ Project development to help address current care challenges

3. Which of the following best describes your role?

- ☐ Current patient
- ☐ Family member/Care Giver
- ☐ Former Patient
- ☐ CalvertHealth Employee or Volunteer

4. Please describe what skills and strengths you would bring to the PFAC group.

5. Please describe any affiliations you have with CalvertHealth and if you have previously served on this committee or any similar.

6. What would your preferred meeting time be?

- [ ] Morning
- [ ] Lunch
- [ ] Afternoon/Evening

7. Preferred contact method:

- [ ] Phone
- [ ] Email
- [ ] Mail

8. How did you hear about this program?

Thank you for taking the time to complete this questionnaire. Someone will be in contact with you regarding program membership within a few weeks of submission.