

PATIENT FAMILY ADVISORY COUNCIL MEMBERSHIP APPLICATION

$Name\ (Last-First-Middle$	2)	
Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	May we contact you at work?YesNo
Please tell us somethin	g about yourself:	
Please tell us why you	would like to be a member of the Pat	tient Family Advisory Council.
What has been your pro	evious experience with Clinton Hosp	ital?
Are you comfortable speaki	ng openly in a large group? Yes No	0
Are you able to make a time	e commitment of one evening meeting per n	nonth?Yes No
Are you able to commit to r	nembership on the council for at least one y	ear? Yes No
Please provide the names of	two (2) persons, other than relatives, whon	n we may contact for personal reference inquiry.
1Name	Address	Telephone number
2. Name	Address	Telephone number

Have you ever been convicted of a felony?YesNo	
If yes, please explain	
I certify that all statements on this application are true and complete. If selected for committee membership, I understated falsification of, or omission from, this application may result in termination of membership from the Patient Family Activities understand:	
 Selection as a Patient Family Advisory Council member is contingent upon CORI check. That Clinton Hospital is a drug-free and smoke-free environment. Council members are volunteers, therefore are required to complete a general orientation relevant to their duti 	es.
SIGNATURE: DATE:	