UMass Memorial Health
HEALTHALLIANCE-CLINTON HOSPITAL

PATIENT FAMILY ADVISORY COUNCIL
MEMBERSHIP APPLICATION

Name (Last – First – Middle) _____

Street Address: _____

City: _____State: _____Zip Code: _____

Home Phone: _____Work Phone: _____

May we contact you at work? __Yes __No

Please tell us something about yourself: _____
_____
_____
_____

Please tell us why you would like to be a member of the Patient Family Advisory Council.
_____
_____
_____
_____
_____

What has been your previous experience with HealthAlliance -Clinton Hospital?
_____
_____
_____
_____

Are you comfortable speaking openly in a large group? ___ Yes ___ No

Are you able to make a time commitment of one evening meeting per month? ____Yes ____ No

Are you able to commit to membership on the council for at least one year? ___ Yes ___ No

Please provide the names of two (2) persons, other than relatives, whom we may contact for personal reference inquiry.

1.
_____
Name Address Telephone number

2.
_____
Name Address Telephone number

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Have you ever been convicted of a felony? ____Yes ___No

If yes, please
explain_____

I certify that all statements on this application are true and complete. If selected for committee membership, I understand that any falsification of, or omission from, this application may result in termination of membership from the Patient Family Advisory Council.
I further understand:

- Selection as a Patient Family Advisory Council member is contingent upon CORI check.
- That HealthAlliance-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 duties.

SIGNATURE: _____DATE: _____

RETURN TO:

Rosa I. Fernandez | Director, Community Health & Volunteer Services
UMass Memorial HealthAlliance-Clinton Hospital
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Clinton, MA 01510

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