



## Application for Patient and Family Advisors

*Please print:*

**Name:** \_\_\_\_\_  
(Last) (First) (M)

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Home Phone: (10 digits)** \_\_\_\_\_ **Cell Phone: (10 digits)** \_\_\_\_\_

**Work Phone: (10 digits)** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Emergency Contact Name and phone:** \_\_\_\_\_

**Language (s) you Speak:** \_\_\_\_\_

**I am/was:** \_\_\_\_\_ A patient \_\_\_\_\_ A family member of a patient

**The dates of my active care experience at RWHS include: (check all that apply)**

\_\_\_ Within the past 5 years \_\_\_ More than 5 years ago \_\_\_ More than 10 years ago

**Times when you are able to engage in PFAC work: (check all that apply)**

\_\_\_ Daytime \_\_\_ Evening \_\_\_ Weekend

**I would be interested in helping with (identify all of your interest areas):**

- Developing/reviewing education materials to improve the patient and family experience.
- Planning for the hospitalization (inpatient) care experience for adults.
- Planning for the hospitalization (inpatient) care experience for children.
- Planning for the emergency care experience.
- Planning for the clinic (outpatient and ambulatory) care experience.
- Planning for the oncology care experience.
- Planning the design of systems of care and facilities for the emergency experience.
- Educating medical students and residents, new employees, and other staff about the experience of care and effective communication support.
- Participating in facility design planning.
- Improving the coordination of care and the transition to home and community care.
- Issues of special interest (please describe):

**Why would you like to serve as an advisor?**

**If you have served as an advisor, been an active volunteer committee member, or done public speaking for other programs or organizations, please briefly describe this experience:**

**Tell us about your or your family's healthcare experience at RWMC. What would you have improved about this experience? What impressed you about this experience?**

**Is there anything that you would like us to know?**

Do you know other individuals and/or families who have experiences care at Regional West who might be interested in serving as advisors? Please call them for us or list their name (s) and phone number(s) here:

Have you ever been convicted or found guilty by a judge or jury of any crime (felony or misdemeanor) that resulted in imprisonment, jail, probation, a deferred sentence, or a fine? (A conviction will not necessarily bar volunteering; seriousness of the offense and rehabilitation will be considered.)  Yes  No If yes, please explain:

Has there ever been a restraining order entered against you by any court for any domestic purposes, physical or verbal abuse or stalking?  Yes  No If yes, please explain and provide date of order and identify court that issued the order along with a case number.

Please read the following carefully before signing this application form:

Regional West patients have the right to privacy. Disclosing any patient confidential information, whether medical or personal data, will result in disciplinary action (as described in Policy #205.0.06 on Disciplinary Action/Dismissal). I certify by my signature that the information I have provided on this application is correct. I authorize investigation of all matters contained in this application and agree that any misleading information, false statements or omissions would be cause for rejection of my application, or would be cause for my dismissal. I voluntarily give Regional West Medical Center the right to make a thorough investigation of my past employment and release from all liability or responsibility all persons, companies or corporations supplying such information. I agree and understand that I must comply with all current and future rules, regulations, policies, procedures, practices and protocols of Regional West Health Services and that I am responsible for compliance with all revisions, and/or additions to rules, regulations policies, procedures, practices and protocols during the course of my volunteer service.

Date\_\_\_\_\_ Applicant's signature\_\_\_\_\_

Please return to:

Kayleen Collopy or Heather Jensen

Regional West Medical Center

4021 Avenue

Scottsbluff, NE 69361

PFAC@rwhs.org

