

**Patient and Family Advisory Council**

**Application**

Thank you for your interest in the Patient and Family Advisory Council (PFAC). The questions in this application are designed to help us insure all aspects of Valley View’s care are represented on the PFAC. Responses are confidential and only shared with those involved in PFAC member screening. Please complete this application and someone will be in contact with you soon to discuss the commitment and fit.

This application can be completed and emailed back to marija.weeden@vvh.org, or you can complete it online here: <https://forms.office.com/r/BrZUGBT0be>

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| **Contact Information** |
| First Name: | Last Name: | Preferred Name: |
|  |  |  |
| Email Address: | City: | Zip code: |
|  |  |  |
| Phone number: | Preferred Language: | Preferred Pronouns: |
|  |  |  |
|  |  |  |
| **Care Experience** |
| I am/was (check all that apply): |
|  □ A patient | □ A family member of a patient | □ A Caregiver of a patient |
| My active experience at Valley View as a patient, family member, or care giver includes any services: |
|  □ Within the last 12 months | □ Within the last 2 to 3 years | □ More than 3 years ago |
| What location(s) did you (or family member or other you cared for) receive care? |
|  □ Glenwood Springs  □ Eagle □ Rifle | □ Carbondale□ New Castle□ Silt | □ Willits/Basalt □ Grand Junction□ Aspen |

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| My care (or your family member or other you cared for) was provided by (check all that apply): |
|  □ Inpatient hospitalization □ Emergency Department □ Family Birth Place □ Urgent Care □ Cancer Center □ Laboratory □ Psychiatry □ Pediatrics | □ Family Practice□ Women’s Health□ Rehab Services□ Imaging□ Orthopedics□ Pharmacy□ Urology□ Palliative Care | □ Spine Center□ Gastroenterology□ Heart & Vascular□ Internal Medicine□ Lung Center□ Breast Center/Plastic Surgery□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How did you hear about the PFAC? |
|  □ Valley View Website  □ Social Media | □ Friend/Family Member/Caregiver□ Event | □ Valley View Employee |
| Why would you like to serve on the Patient and Family Advisory Council? |
|  |
| Tell us about your or your family’s healthcare experience. What would you have improved about this experience? What impressed you about this experience? |
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CONFIDENTIALITY: All information contained in this form is considered confidential and is intended for use by a Valley View Patient and Family Advisory Council Membership Committee.

All patients and families served by Valley View are welcome to apply for membership on the Patient and Family Advisory Council.

By signing, I am stating that I understand that if selected to participate in the Patient and Family Advisory Council, I will be committing to 12 months of participation. This will include participation in at least 6 of the 9 meetings throughout the year.

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Applicant Signature Date