COFFEY COUNTY HOSPITAL

PATIENT/FAMILY ADVISOR APPLICATION

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle)

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

(Street) (Contact Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip) (County)

Preference of contact \_\_\_\_ phone \_\_\_\_\_ email \_\_\_\_\_\_\_ text

If text, please, provide the name of your carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you served on a patient/family advisory council (PFAC) in the past? \_\_\_\_\_\_ YES \_\_\_\_\_\_ NO

How did you learn about this program? \_\_\_\_ The Insider \_\_\_\_\_\_ Coffey Health System website

\_\_\_\_\_ Facebook \_\_\_\_ friend or relative \_\_\_\_ other

What is your interest in being a member of a Patient Family Advisory Council?

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(Please attach additional paper if needed)

What experiences have you had with Coffey County Hospital?

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Have you served as a patient advocate? \_\_\_\_ Yes \_\_\_\_\_ No

List your participation in other community service or advocacy organizations. (Churches, clubs, organizations)

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