HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

VOLUNTEER PATIENT FAMILY ADVISORY COUNCIL APPLICATION

Thank you for your interest in the Howard County General Hospital (HCGH) Volunteer Patient Family Advisory Council. We are selecting patients or family members to join the Council. Please complete this short questionnaire. Select applicants will be contacted to schedule an interview.

| VOLUNTEER APPLICANT INFORMATION | | | |
|---|---|---|---|
| Last Name | First Name | M.I. | Date |
| Street Address | | Apartment/Unit # | |
| City | State | County | ZIP |
| Phone (Day) | Phone (Evening) | | Phone (Other) |
| E-mail Address | | | |
| Emergency Contact Name: | Relationship: | Phone #: | |

What area of the hospital have you or your family member(s) used? (Please check all that applies.)

| AREA | RECEIVED SERVICE WITHIN 6 MONTHS | RECEIVED SERVICE WITHIN LAST YEAR |
|---|---|---|
| Inpatient – Medical | | |
| Inpatient – Surgical | | |
| Inpatient – Women's & Children's Services | | |
| Emergency Department | | |
| The Bolduc Family Outpatient Center | | |
| Diagnostic Imaging (X-ray, CT, MRI, Ultrasound, NucMed, Breast Health) | | |
| Outpatient Surgery | | |
| Oncology | | |

What is your relationship(s) to the patient above?

☐ I am the patient ☐ Spouse/Significant Other ☐ Parent ☐ Adult Child ☐ Sibling ☐ Other: _____

Have you experienced the loss of a family member at HCGH? ____ Yes _____ No

Why are you interested in being on the Volunteer Patient Family Advisory Council?

_____
_____
_____
_____

What are some specific things that health care professionals did or said that was most helpful to you and your family?

_____
_____
_____
_____

What are some specific things that you or your family would like health care professionals to do differently in order to be more helpful to you and your family?

_____
_____
_____
_____

Is there something else you think we should know about you?

_____

_____

_____

_____

To what other community organizations do you belong?

_____

_____

_____

_____

Would you be able to make a commitment of two years? ☐ Yes ☐ No

Best time for meetings: ☐ Days ☐ Evenings

The following are the ways you can be involved in the Council. We do not expect you to have extensive experience in health care but we are interested in learning more about your experiences. Training will be offered for any activity that interests you. Time commitment is approximate and cannot be guaranteed. Please check boxes below that apply.

- ☐ Advisory Council: Membership on the Council to offer input on planning, programs and other pertinent matters; identify patient and family concerns and partner with staff to advise and promote patient family centered care. (Time Commitment: Attend at least 75% of monthly meetings for a term of two years. Meetings will be no longer than two hours.)
- ☐ Sub-Committee: Membership on a specific sub-committee that is charged with a particular responsibility such as conferences, reviewing brochure/websites, new program development, new facilities, etc. collaborating with staff and offering the family perspective.
- ☐ Task Force: Occasional family/patient group meetings to give feedback or suggest solutions on a specific topic.

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have provided accurate information to the best of my ability.

Signature: _____ Date: _____

SEND COMPLETED APPLICATION FORM TO:

Department of Patient Experience
Howard County General Hospital
5755 Cedar Lane
Columbia, MD 21044

Please allow 2-4 weeks for processing. Applicants will be considered based on the needs of the committee.

Health Screening and criminal clearances will be required prior to active participation in the Patient Family Advisory Council.
(Screenings; TB, flu shot, up-to-date immunizations)