

## Patient & Family Advisory Council Membership Application

Thank you for your interest in the Patient & Family Advisory Council (PFAC). Membership on PFAC requires your successful completion of a formal interview with a PFAC member and the completion of the registration process with the Johns Hopkins Bayview Medical Center's Volunteer Services Department, including TB testing, a criminal background check, a formal interview process, as well as a mandatory volunteer orientation.

All of your information will be treated as confidential. Membership on the Council requires attendance at quarterly meetings.

**Please PRINT all information clearly:**

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

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

City/State/Zip Code: \_\_\_\_\_

Telephone number(s): Please indicate preferred phone number and best time to reach you: \_\_\_\_\_

Work: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*Being environmentally conscience, the majority of the Council's correspondence is via email. If you do not have email, please do not worry and write **I do not have email**. The Council will use postal mail or telephone contact as forms of communication with you.*

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

**Please indicate if you are:**

- Person with dementia
- Family member of person with dementia
- Bereaved family member

If family member, what is relationship to patient? \_\_\_\_\_

Diagnosis (cause of dementia) \_\_\_\_\_

Year of original diagnosis \_\_\_\_\_

How long have been receiving care for the dementia diagnosis at Johns Hopkins? \_\_\_\_\_

*Please indicate estimated months/years*

Why would you like to become a member of the Council?

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

Received by the Council: \_\_\_\_\_

Comments related to treatment experience(s):

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*Please read before signing*

**I certify that the statements made in this application are true and correct and have been given voluntarily. I understand that I will not be paid for my services as a volunteer member of the Patient and Family Council. I agree to respect patient confidentiality and to uphold the traditions and standards of the Johns Hopkins Medical Institution. I understand that membership on the Patient & Family Council is based on approval from the Council Co-Chairpersons and Staff Liaison. Volunteers will demonstrate a readiness to help others, maintain respect for collaboration and assist the Memory Center in delivering quality patient dementia care.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please return completed application via mail or fax to: Patient & Family Advisory Council*  
The Johns Hopkins Memory and Alzheimer's Treatment Center  
5300 Alpha Commons Dr. 4<sup>th</sup> Floor  
Baltimore, MD 21224  
Fax: 410-550-5992

If interested please contact us by telephone at 410.550.9031

