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?

_____

_____

Comments related to treatment experience(s):

_____

_____

_____

_____

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, email or fax to:

Andrea Nelson, RN, MSN – Director of Memory Care Programs
Staff Liaison - Patient & Family Advisory Council
The Johns Hopkins Memory and Alzheimer's Treatment Center
5300 Alpha Commons Dr. 4th Floor
Baltimore, MD 21224
410-550-7211
Fax: 410-550-1407
anelso18@jhmi.edu

THE JOHNS HOPKINS
Memory & Alzheimer's
TREATMENT
CENTER