PFAC APPLICATION

Patient and Family Advisory Council
Highlands Medical Center

NAME: _____
(First) (Middle) (Last)

HOME ADDRESS: _____
(Street) (City) (State) (Zip Code)

☐ **CHECK HERE IF MAILING ADDRESS IS SAME AS HOME ADDRESS**

MAILING ADDRESS: _____
(Street) (City) (State) (Zip Code)

CHECK PREFERRED PHONE NUMBER FOR BUSINESS HOURS:

☐ **HOME PH:**_____ ☐**WORK PH**:_____ ☐**CELL PH:** _____

EMAIL ADDRESS:_____**PREFERRED CONTACT METHOD:** ☐Phone call ☐Email ☐Text

PLEASE LIST THE LANGUAGE(S) YOU SPEAK: _____

AGE GROUP: ☐18-25 ☐26-40 ☐41-55 ☐55-70 ☐70-80 ☐81+

DO YOU GIVE HIGHLANDS MEDICAL CENTER PERMISSION TO SHARE YOUR CONTACT INFORMATION WITH OTHER COUNCIL MEMBERS?

☐ Yes, you may disclose my contact information with other PFAC members if requested.
☐ No, I do not want my contact information shared with other PFAC members

SELECT ALL THAT APPLY:

☐ I am/have been a patient of Highlands Medical Center or have utilized a service provided by the hospital.
☐ I am the family member or caregiver of a patient who utilizes services provided by Highlands Medical Center.
☐ I am a community member seeking to assist the hospital in growing with the community it serves.

IF YOU HAVE UTILIZED SERVICES PROVIDED BY ALH, PLEASE CHECK BELOW:

☐ Hospitalization (inpatient)
☐ Outpatient surgical services (ambulatory surgery)
☐ Clinic visit (Medical practice)
☐ Emergent care (ED)
☐ Diagnostic testing (outpatient)

☐ Other: _____

PLEASE INDICATE HOW MANY EXPERIENCES YOU HAVE HAD AT HMC FACILITIES IN THE PAST 2 YEARS:

☐ None
☐ 1-5
☐ 6-10
☐ 10 or more

WITHIN THE PAST 2 YEARS, WHAT HMC SERVICES HAVE YOU OR YOUR FAMILY MEMBER USED?

☐ I nor my family members have utilized any services at HMC within the past 2 years.

☐ Physician's office
☐ Intensive Care Unit (ICU)
☐ Highlands Wound Care Center
☐ Educational classes
☐ Therapy Department
☐ Pregnancy, Childbirth and/or Infant Care
☐ Surgery
☐ Pediatrics
☐ Diagnostic Testing (lab, respiratory & imaging)
☐ Emergency Department
☐ HMC Main
☐ The Sleep Center
☐ Pharmacy

☐ Other: _____

DO YOU HAVE ANY SPECIAL NEEDS WE SHOULD BE AWARE OF? ☐No ☐Yes:_____

WHAT WOULD THE PATIENT & FAMILY ADVISORY COUNCIL FIND VALUABLE FROM YOUR EXPERIENCES WITH HIGHLANDS MEDICAL CENTER?

_____

_____

_____

_____

PLEASE LIST ANY SUGGESTED TOPICS THAT YOU WOULD LIKE THE PFAC TO DISCUSS DURING MEETINGS:

_____

_____

_____

_____

BY SIGNING BELOW, I AM AFFIRMING THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUTHFUL TO THE BEST OF MY KNOWLEDGE. I AGREE TO VOLUNTARILY JOINING THE PATIENT AND FAMILY ADVISORY COUNCIL AT HIGHLANDS MEDICAL CENTER AND UNDERSTAND THAT MY TERM OF SERVICE IS FOR ONE YEAR, OCCURING IN THE CALENDAR YEAR 2025. ADDITIONALLY, I AGREE TO VOICE MY FEEDBACK AND SHARE MY EXPERIENCES IN A MANNER THAT IS CONSCIOUSLY RESPECTFUL AND COURTEOUS TO ALL COUNCIL MEMBERS.

X _____ **DATE:** _____