



PATIENT/FAMILY  
ADVISORY  
COUNCIL  
APPLICATION



*Dedication. Compassion. Innovation.*

# MEMORIAL HOSPITAL

## PATIENT/FAMILY ADVISORY COUNCIL APPLICATION

Thank you for your interest in Memorial's Patient/Family Advisory Council. The purpose of the Patient/Family Advisory Council is to act as an advisory resource for Memorial Hospital to enhance patient and family collaboration with hospital administration, management, physicians and staff in creating a patient/family centered culture to meet Memorial's mission of ***providing exceptional healthcare and compassionate service.***

The Council will be comprised of patients, family members and friends. Please complete this application. Selected applicants will be contacted to schedule an interview and supply a list of references. Selected members must be available to attend a new member orientation.

If you have any questions, please call 618-257-5603 or email [cceasy@memhosp.com](mailto:cceasy@memhosp.com).

<b>APPLICANT INFORMATION</b>			
Last Name	First Name	Middle Initial	Date
Street Address		Apartment/Unit #	
City	State	County	Zip Code
Phone (Day)		Phone (Evening)	
E-Mail Address			

Best time to be contacted:      \_\_\_ Daytime      \_\_\_ Evenings      \_\_\_ Weekends

Age range:    \_\_\_ 20-30    \_\_\_ 31-40    \_\_\_ 41-50    \_\_\_ 51-60    \_\_\_ 61-70    \_\_\_ 70+

Language(s) you speak? \_\_\_\_\_

We believe the Council should reflect the diversity of our patients and families. In light of this, please share anything about yourself that you think would add to the diversity of our Council. You might consider diversity to be ethnic, racial, spiritual, social, economic, gender, disability related, etc.

## PATIENT VISITS

<i>In the past two years, how many times have you:</i>	0	1	2	3-5	More than 5
- been an inpatient at Memorial?					
- visited an outpatient department?*					
- visited the Emergency Department?					

\* If you had an experience with outpatient department(s), please specify: \_\_\_\_\_

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## FAMILY MEMBER VISITS

<i>In the past two years, how many times has one of your family members:</i>	0	1	2	3-5	More than 5
- been an inpatient at Memorial?					
- visited an outpatient department?*					
- visited the Emergency Department?					

\* If your family member had an experience with outpatient department(s), please specify: \_\_\_\_\_

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Would you be able to serve on the Council for a two-year term?    \_\_\_ Yes    \_\_\_ No

If "no," how long? \_\_\_\_\_

Best time for meetings:    \_\_\_ Days    \_\_\_ Evenings    \_\_\_ Weekends  
                                      \_\_\_ Breakfast    \_\_\_ Lunch    \_\_\_ Dinner

Have you previously served at another organization as an advisor, been active as a volunteer, a committee member or served on a board of directors?    \_\_\_ Yes    \_\_\_ No

If "yes," please describe the experience: \_\_\_\_\_

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Please tell us why you are interested in serving on Memorial's Patient/Family Advisory Council and why you feel you would be a good representative for other patient/families. (Use the back of this form and/or additional sheets if necessary):

(please continue)

**ACKNOWLEDGEMENT AND SIGNATURE**

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**RETURN COMPLETED APPLICATION TO:**

Patient/Family Advisory Council  
ATTN: Cheryl Creasy  
Memorial Hospital  
4500 Memorial Drive  
Belleville, Illinois 62226

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