PFAC APPLICATION

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 ATHENS-LIMESTONE HOSPITAL 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 Athens-Limestone Hospital or have utilized a service provided by the hospital.
☐ I am the family member or caregiver of a patient who utilizes services provided by Athens-Limestone Hospital.
☐ 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 ALH FACILITIES IN THE PAST 2 YEARS:

☐ None
☐ 1-5
☐ 6-10
☐ 10 or more

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

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

☐ Physician's office
☐ Cardiology
☐ Intensive Care Unit (ICU)
☐ Advanced Wound Care Center (AWCC)
☐ Orthopedics
☐ Educational classes
☐ Pregnancy, Childbirth and/or Infant Care
☐ Surgery
☐ Medical East
☐ Pediatrics
☐ Diagnostic Testing (lab, respiratory & imaging)
☐ Emergency Department
☐ ALH Main
☐ ALH Medical East/ LMV
☐ 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 ATHENS-LIMESTONE HOSPITAL?

_____

_____

_____

_____

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 ATHENS-LIMESTONE HOSPITAL AND UNDERSTAND THAT MY TERM OF SERVICE IS FOR ONE YEAR, OCCURING IN THE CALENDAR YEAR 2022. 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:** _____