ASPIRUS
Passion for excellence. Compassion for people.

PATIENT & FAMILY ADVISORY COUNCIL APPLICATION

DATE: _____ *(Please Print)*

PERSONAL

Name:_____
(First) *(Middle)* *(Last)*

Address: _____
(Street Address) *(City)* *(State)* *(Zip)*

E-mail address: _____

Primary phone #: _____ (home / cell / work) Alternate phone #: _____

Age Group (please circle one): Under 18 18-25 25-65 65+

Person to contact in case of emergency: _____ Relationship: _____ Phone:_____

AVAILABILITY

Date available to volunteer: _____

Days available (circle all that apply): Monday Tuesday Wednesday Thursday Friday

Meeting preference time: _____ (am / pm) _____ In Person _____ Conference Call only

Club/Organization Affiliations and/or Special Training:

_____
_____
_____

GENERAL

Briefly explain why you would like to join the Aspirus Patient & Family Advisory Council:

_____
_____
_____

Most important skill I can bring to Patient & Family Advisory Council is:

_____
_____

In the past three years, have you been:

a patient at Aspirus Medford Hospital ☐ yes ☐ no
or a family member (or close friend) of a patient ☐ yes ☐ no

In your opinion, how could Aspirus better serve patients & families: _____

_____
_____
_____

REFERENCES

Please list two references that are not relatives. Physical addresses are required.

Name _____ Name _____

Address _____ Address _____

City, State, Zip: _____ City, State, Zip: _____

Telephone or cell #: _____ Telephone or cell # _____

Email address: _____ Email address: _____

Relationship _____ Relationship _____

READ AND SIGN:

Our policy is to select and train the best-qualified individuals without regard to race, color, religion, creed, sex, national origin, age, disability, citizenship, veteran or marital status. Volunteers are placed according to their interests as much as they match the needs of the health center. During the first 60 days, the volunteer is in an introductory status.

In compliance with State Law, I understand that I must sign an authorization for a **criminal history check**. The disclosure form will be kept confidential. However, the results of this disclosure may determine my suitability for volunteer service at Aspirus Medford Hospital & Clinics.

The information provided in this application is true in all respects, without any willful omissions. I understand that if I am selected as a volunteer, any false or misleading statements on this or any company document may result in immediate dismissal without notice regardless of when the false information is discovered.

As a Patient Family Advisory Council volunteer, I…

- Agree to complete the Patient & Family Advisory Council volunteer orientation as required.
- Agree to comply with all the rules and regulations of Aspirus Medford Hospital & Clinics.
- Understand additional education and medical clearance is necessary to hold other volunteer positions.
- Understand that I may be dismissed from my duties for willful wrongdoing or negligence and/or performing duties outside of my PFAC service guidelines.
- Understand the volunteer relationship is for an indefinite period and may be terminated at any time for any reason, either by the volunteer or the health center.

_____ _____

Signature of Applicant Date

Return application to: Volunteer Coordinator Aspirus Medford Hospital 135 South Gibson Street Medford, WI 54451