APPLICATION FOR PATIENT AND FAMILY ADVISORY COUNCIL Boulder Community Health

Please complete the following:

Name: _____
(Last) (First) (MI)

Address: _____
(Street Address, City, State, Zip Code)

Home Phone: (10 digits) _____ **Cell Phone:** (10 digits) _____

E-mail Address: _____

Language(s) You Speak: _____

Will you allow your contact information to be shared with other advisory council members? Yes / No

I am/was: □ A patient □ A family member of a patient

My care is/was provided by: _____

(Department)

□ Hospitalization (inpatient) □ Emergency Room (ER) □ Clinic visit (outpatient) □ Outpatient Procedure

□ Both inpatient and outpatient □ Imaging □ Other programs, departments, or services

The year of my care experience at Boulder Community Health: (check all that apply)

□ 2020 □ 2021 □ 2022 □ 3 years ago or more

Why would you like to serve as an advisor?

If you have served as an advisor, been an active volunteer committee member, or done public speaking for other programs or organizations, please briefly describe this experience:

What unique skill set or perspective do you bring to the council?

Is there anything else you would like to share?

Please email this form to PFAC@bch.org