Children's Hospital of The King's Daughters
Patient/Family Advisory Council
Membership Application

Note: Membership on the Patient/Family Advisory Council is a volunteer position. As such, members must meet hospital volunteer requirements, which include, but are not limited to, a criminal background check, education about federal privacy and confidentiality regulations, and participation in the mandatory influenza vaccination program.

Date: _____ **Applicant's Name:** _____

Child's/Children's Name(s) and Age(s): _____

Mailing Address: _____

E-mail: _____ **Preferred phone:** _____

What is the best way to contact you? □ Phone □ E-mail **Best time to contact:** _____

Did someone recommend you for Council membership? □ Yes □ No **If yes, who?** _____

Have any of your children been hospitalized at CHKD? □ Yes □ No

If yes, which child(ren)? _____

Date of first admission: _____ Date of last admission: _____

Age(s) of child(ren) admitted: _____

Which patient care units have served your child(ren)? _____

_____

_____

What medical conditions do(es) your child(ren) face? _____

_____

_____

Have you used outpatient services at CHKD? □ Yes □ No

Which child(ren)? _____

Which clinics or services (e.g., radiology or laboratory) were used and when? _____

_____

_____

What does "good customer service" mean to you and your family when you use hospital services? _____

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_____

[Please turn over]

If you were talking to a group of doctors, nurses, administrators and other employees of CHKD, how would you describe a day in the life of your child and your family in terms of the medical needs of your child? Think about the things you would want them to know so that they see your family's world outside of the hospital.

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What are some of the things you'd like health care professionals to do differently to better help your family? _____

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What are some of the things that CHKD does well? _____

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What areas of concern would you like to see the Patient/Family Advisory Council address? _____

_____

_____

What special interest and/or experiences would you bring to the Council? _____

_____

_____

CHKD believes that the Council should reflect the cultural diversity of families who are consumers of hospital services. Please share anything about yourself that you think would add to the diversity of the Council. Among other things, you may consider your diversity to be ethnic, racial, spiritual, social, economic, educational, geographic, sexual orientation, unique family structure, or disability. No information will be shared with others without your permission.

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We request that you submit a letter of reference from a Health System staff member. The letter can be written by a doctor, nurse, social worker, chaplain, housekeeper or anyone else who can speak to your ability to be involved in this type of a leadership program. Please ask them to submit the letter via e-mail to pfac@chkd.org or mail it to Family Advisory Council, c/o Patient Experience Services, 601 Children's Lane, Norfolk, VA 23507. Please use the same e-mail or mailing address to submit this application.