

# SwedishAmerican Patient & Family Advisory Council

## Member Application

### Your Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

### Employment History:

Company Name: \_\_\_\_\_

Type of Work: \_\_\_\_\_ Current Status: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

Company Name: \_\_\_\_\_

Type of Work: \_\_\_\_\_ Current Status: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

List Professional or Business Experience:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Education History

	Name and Location	Year of Graduation	Degree/Major/Subject of Study
High School or GED			
College or University			
Specialized Training			
Other			

**Volunteering Information**

List any Volunteer Experience (Organization, Type of Work and Reason for Leaving):

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Please give two non-relative references that we may contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Why do you want to join the SwedishAmerican Patient and Family Advisory Council?

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Have you or a loved one been a patient at SwedishAmerican Health System within the last two years? If so, in what capacity/area/department were you a patient?

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Did we meet your service, safety and quality expectations during your visit?

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What could the health system have done to better meet your expectations?

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What would you like us to learn from your experience?

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*(Please feel free to use additional pages, if needed.)*

Do you feel comfortable working in groups, speaking up and providing input?

Yes  No

Is English the language you primarily use when communicating with family & friends?

Yes  No

If your answer is no, what is your primary language? \_\_\_\_\_

Are you able to attend monthly meetings at SwedishAmerican during weekday evenings?

Yes  No

***Please note all SwedishAmerican Health System volunteers will undergo a background check and are required to comply with our immunization and health mandates. All volunteers are also required to sign an agreement not to disclose any confidential information that may be shared during the Patient & Family Advisory Council meetings.***

**Is there anything more you would like us to know as we review and consider your application for volunteering on the SwedishAmerican Patient and Family Advisory Council?**

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