Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING AFFILIATE

CHA PATIENT AND FAMILY ADVISORY COUNCIL MEMBERSHIP APPLICATION

Name (Last, First, Middle)_____

Street Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Work Phone: _____

May we contact you at work? __Yes __No

*Please tell us something about yourself:*_____
_____
_____
_____
_____
_____
_____

Please tell us why you would like to be a member of our Patient And Family Advisory Council:
_____
_____
_____
_____
_____
_____

Do you have any previous experience with Cambridge Health Alliance? Please tell us about it:
_____
_____
_____
_____
_____
_____

Are you comfortable speaking openly in a large group? ___ Yes ___ No

Are you able to make a time commitment of one evening meeting per month? ____Yes ____ No

Are you able to commit to membership on the council for at least one year? ___ Yes ___ No

Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING AFFILIATE

Please provide the names of two (2) persons, other than relatives, whom we may contact as a personal reference:

Reference 1._____
_____
Please include Name, Address, and Telephone number

Reference 2._____
_____
Please include Name, Address, and Telephone number

Have you ever been convicted of a felony? ____Yes ___No

If yes, please explain_____

I certify that all statements on this application are true and complete. If selected for committee membership, I understand that any falsification of, or omission from, this application may result in termination of membership from the Patient Family Advisory Council.

I further understand:

- Selection as a Patient Family Advisory Council member is contingent upon CORI check.
- Council members are volunteers, therefore are required to complete a general orientation relevant to their duties.

SIGNATURE: _____

DATE: _____