

## Patient & Family Advisory Council Application

1. Today's Date:

2. Contact Information (*please print*):

Name:

Home Address:

City/State/Zip:

County:

Daytime Phone:

Best day/time to call:

Evening Phone:

Best day/time to call:

Email Address:

3. Within the past two years have you used any of the following services at Oconomowoc Memorial Hospital? (*Check all that apply*)

- Emergency Room     Inpatient Care     Outpatient Clinic     Surgery  
 Lab     X-ray     Other: \_\_\_\_\_

4. Have you used other community-based services within the past two years?  
(*Check all that apply*)

- Specialty Clinics     Angel's Grace Hospice     Home Health Care  
 Other: \_\_\_\_\_

5. **References** (*if any*):

If you were referred by a ProHealth Care employee, please include their name below. If you would like to provide additional references please attach an additional piece of paper.

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

6. I give permission to the Family Advisory Council (or their designee) to discuss my application with the above reference.

Name (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

**7. Tell Us More About Yourself and Your Experiences**

- a. Why would you like to be involved on the Family Advisory Council?
  
  
  
  
  
  
  
  
  
  
- b. We believe the Family Advisory Council should reflect the cultural diversity of families who are consumers of hospital services. Please share anything about your family that you think would add to the diversity of this program. You might consider your diversity to be: ethnic, racial, age, spiritual, social, economic, educational, geographic, gender, sexual orientation, unique family structure, disability-related, chronic illness, single parent, full-time parent, grandparents, etc.
  
  
  
  
  
  
  
  
  
  
- c. Is there anything else you would like us to know?

I understand that completion of this application does not bind the applicant or the program coordinators in any way. Oconomowoc Memorial Hospital reserves the right to choose participants that best meet the needs of the Committee. Before participating, you will be asked to sign a confidentiality agreement.

Name (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

***Thank you for your interest!***

**Please mail or fax your application to either:**

Christine Shaw, Clinical Care Partner  
Oconomowoc Memorial Hospital  
791 E. Summit Avenue,  
Oconomowoc, WI 53066  
Phone: (262) 569-0234  
Email: christine.shaw@phci.org

Anne Bitz, Administrative Assistant  
Oconomowoc Memorial Hospital  
791 E. Summit Avenue  
Oconomowoc, WI 53066  
Phone: (262) 560-4550  
Fax: (262) 569-0565  
Email: anne.bitz@phci.org

Please contact Christine with any questions either by phone or e-mail.  
Thank you!