APPLICATION FOR PATIENT, RESIDENT, AND FAMILY ADVISORS

NAME_____
(LAST) (FIRST) (MI)

ADDRESS:_____

CITY, STATE, ZIP CODE:_____

HOME PHONE: (10 digits)_____CELL PHONE (10 digits) _____

E-MAIL ADDRESS:_____

EMERGENCY CONTACT NAME AND PHONE:_____

LANGUAGE YOU SPEAK:_____

WILL YOU ALLOW YOUR CONTACT INFORMATION TO BE SHARED WITH OTHER COMMITTEE/ADVISORY COUNCIL MEMBERS? ____YES ____NO

IAM/WAS: ____PATIENT ____FAMILY MEMBER OF A PATIENT/RESIDENT

MY CARE IS/WAS PROVIDED BY (provider) _____

CHECK ALL THAT APPLY:

____HOSPITALIZATION (INPATIENT) ____EMERGENCY DEPARTMENT CARE

____CLINIC VISIT ____OUTPATIENT SERVICES ____ LONG TERM CARE

THE DATES OF MY ACTIVE CARE EXPERIENCE AT LCHS INCLUDE: (CHECK ALL THAT APPLY)

____CURRENT/WITH IN THE PAST 5 YEARS ____MORE THAN 5 YEARS ____MORE THAN 10YEARS

PLEASE SPECIFY TIMES WHEN YOU ARE ABLE TO ATTEND MEETINGS (CHECK ALL THAT APPLY):

____DAYTIME:_____ ____EVENING:_____ ____WEEKEND:_____

WHY WOULD YOU LIKE TO SERVE AS AN ADVISOR?

TELL US ABOUT YOU OR YOUR FAMILY'S HEALTHCARE EXPERIENCE AT LCHS. WHAT WOULD YOU HAVE IMPROVED ABOUT THE EXPERIENCE? WHAT IMPRESSED YOU ABOUT THE EXPERIENCE?

IS THERE ANYTHING YOU WOULD LIKE US TO KNOW?

I WOULD BE INTERESTED IN HELPING THE IN: (IDENTIFY ALL OF YOUR INTEREST AREAS)

_____ REVIEWING PATIENT AND FAMILY SATISFACTION TOOLS

____DEVELOPING/REVIEWING EDUCATIONAL MATERIALS

____PLANNING FOR THE HOSPITALIZATION (INPATIENT) CARE EXPERIENCE

____PLANNING FOR THE SURGICAL EXPERIENCE

____PLANNING FOR THE EMERGENCY CARE EXPERIENCE

____ENSURING PATIENT SAFETY AND THE PREVENTION OF MEDICAL ERRORS

____PARTICIPATING IN FACILITY DESIGN PLANNING

____IMPROVING THE COORDINATION OF CARE AND THE TRANSITION TO HOME AND COMMUNITY CARE

____IMPROVING BILLING EXPERIENCE

____DEVELOPING USES FOR INFORMATION TECHNOLOGY, INCLUDING ELECTRONIC MEDICAL RECORS, PATIENT PORTALS, AND ELECTRONIC PERSONAL HEALTH RECORDS

____SERVING AS AN e-ADVISER, RESPONDING BY EMAIL TO QUESTIONNAIRES AND SURVEYS SEEKING YOUR OPINIONS

____LONG TERM ADVISORY COUNCIL MEMBERSHIP TO HAVE IMPACT AND INFLUENCE ON POLICIES AND PRACTICES THAT AFFECT THE CARE AND SERVICES AT THE LOGAN COUNTY MANOR.

BRIEFLY DESCRIBE OR STATE IF YOU HAVE BEEN A VOLUNTEER OR BOARD MEMBER AT LCHS BEFORE:

HAVE YOU DONE ANY PUBLIC SPEAKING OR TEACHING? IF SO PLEASE DESCRIBE:

DO YOU KNOW OTHER INDIVIDUALS AND OR FAMILIES WHO HAVE EXPERIENCED CARE WITH LCHS WHO MIGHT BE INTERESTED IN SERVING AS ADVISORS? PLEASE CALL THEM OR LIST THEIR NAME AND CONTACT INFORMATION.

PLEASE RETURN FORM TO:

Victoria Swanson
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