



# PATIENT AND FAMILY ADVISORY COUNCIL

## APPLICATION

---

Thank you for your interest in serving as an advisor for the Patient and Family Advisory Council (PFAC) at Capital Health. The purpose of this group is to assist Capital Health in improving its patient care experience and delivery of health care services to its community. Please fill out this brief application.

Your application will be reviewed by a selection committee. The commitment to serve on this advisory council is two years, with a minimum attendance at monthly meetings. Placements on advisory councils are based on available openings, a candidate's interests and experience, and the needs of Capital Health.

*WHEN FILLING OUT THE APPLICATION, PLEASE PRINT.*

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

Address \_\_\_\_\_

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

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Preferred method of contact:  Cell Phone  Work Phone  Email

Race/Ethnicity \_\_\_\_\_ Pronouns \_\_\_\_\_ Age \_\_\_\_\_

Language(s) you speak: \_\_\_\_\_  
\_\_\_\_\_

We are hoping to find advisors that reflect the diverse experiences of patients and families who use our hospital and practices. Please answer the following questions regarding your experience at Capital Health.

Within the past two years, I am or have been:

- A patient  A family member of a patient  Both patient and family member

Within the past two years, my care at the Capital Health included:

- Hospitalization (inpatient)  Clinic visit (outpatient)  
 Both inpatient and outpatient  Emergency Department care

How are you currently involved in improving your community? (list affiliations/involvement):

---

---

---

---

---

---

Please tell us why you are interested in serving as a patient and family advisor and why you feel you would be a good representative for other patients and families:

---

---

---

---

---

---

Have you previously served at another organization(s) as an advisor, been a volunteer committee member, or sat on a board of directors?  Yes  No

If yes, please describe your experience:

---

---

---

---

---

---

The PFAC meets monthly. If selected to be a patient and family advisor, which days of the week are you available to meet in person for PFAC meetings? *(Select all that apply)*

- Monday  Tuesday  Wednesday  Thursday  Friday

**Please return this application to [sochs@capitalhealth.org](mailto:sochs@capitalhealth.org) or mail to:**

Sandee Ochs, Patient Advocate

Capital Health, One Capital Way, Pennington, New Jersey 08534

If your application matches open slots for advisors, we will contact you for an interview.

If you have any questions about this application or the Perinatal Community Advisory Board, please contact the Patient Advocate at 609-303-4280.

We hope that you will consider being a patient and family advisor. Please share this with other Capital Health patients and families you know who might like to get involved.

We look forward to partnering with you. Thank you.



**capitalhealth**