PATIENT & FAMILY ADVISORY COUNCIL APPLICATION

PLEASE PRINT

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

Have you been cared for by Williamson Health within the last 2 years? ☐ Yes ☐ No
Has a family member been cared for by Williamson Health within the last 2 years? ☐ Yes ☐ No

Have you previously been an employee or volunteer for Williamson Medical Center? ☐ Yes ☐ No
If yes, state the final position held, termination date, and reason for leaving. _____

_____

Have you been convicted of a crime other than a misdemeanor? ☐ Yes ☐ No If yes, describe in full, including dates. _____

_____

DEMOGRAPHIC INFORMATION

The information collected below is optional.

Date of birth: _____

Occupation (If you are retired, what was your occupation/career before you retired? _____

_____

SKILLS AND EXPERIENCE

Why are you interested in serving on the PFAC for Williamson Health? _____

_____

_____

_____

Do you have any prior experience on advisory councils, boards, or in other similar capacities? Please describe your experiences. _____

_____

_____

REFERENCES

Individuals should not be related to you.

1. _____ Phone: (_____) _____

2. _____ Phone: (_____) _____

3. _____ Phone: (_____) _____

IN CASE OF AN EMERGENCY, CONTACT:

1. First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

Work Phone: (_____) _____

Relationship: _____

2. First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

Work Phone: (_____) _____

Relationship: _____

The undersigned agrees to abide by all Williamson Health rules and regulations. Permission is granted to Williamson Health to investigate references and criminal background. I release from liability or responsibility all people, places of businesses, and municipalities supplying such information.

I certify the above statements are made truthfully and realize falsification may result in dismissal. I understand my membership will be subject to a satisfactory investigation report, check of my references, and post-medical screening. Either party may terminate my membership at will upon notice to the other.

Signature: _____ Date: _____