Received by PFAC Office: _______________

Patient and Family Advisory Council (PFAC) Membership Application

Milford Regional Medical Center Patient and Family Advisory Council (PFAC)

Thank you for your interest in the Patient and Family Advisory Council. Membership on the Council requires successful completion of the application process with the Milford Regional Medical Center. The application process includes but is not limited to: 1)Having been a patient or are a family member of a patient who has received services at the Medical Center within the last five years or are a current MRMC staff member, 2) Successful completion of a health screening to include a TB test, 3)Successful completion of a criminal background check, 4)Completion of a formal interview process, and 5) Completion of a mandatory orientation. All of your information will be held in the strictest of confidences. Membership on the Council requires attendance at monthly Council meetings with the possible option to participate on other sub-committees.

Please PRINT all information clearly:

Name: ____

Address: ________________________________ City/State/Zip Code ___________________________

Preferred Language _____________________________ Interpreter Services Requested ____________

Current or previous occupation____

Military Service (circle one) Y N

Contact information:

Preferred phone number _________________ Best time to reach you __________________am/pm

Alternative contact information:

Work _____-_____-________ Home _____-_____-_______ Cell _____-_____-_______

Fax _____-_____-________ E-Mail address____

Please indicate if you are:

☐ Adult Patient ☐ Family Member of Patient ☐ MRMC Staff

Date of last admission or services @ the Medical Center:

Applicant __________________________ Family Member______________________________

What did your/your family member's care involve? [Check all that apply]

☐Surgery ☐Medical Condition ☐Outpatient Services Type___________________ ☐VNA/Hospice

____

List previous experience for organizations/committees/councils on which you have participated or volunteered____

____

Why would you like to become a member of the PFAC?

____

____

____

Please list area(s) of special interest within the Medical Center (if applicable):

____

____

Comments related to patient and/or family experience(s):

____

____

____

List any other <u>work</u> and/or <u>life</u> experience that you feel is relevant to your application:

____

____

____

Conditions of PFAC Membership ***(Please read before signing):***
Prior Convictions ***(Please read this carefully before answering)***
Please answer the following question below. Please know that you may answer "NO" to the question below if you have a criminal record which is: (a) A sealed record on file with the commissioner of Probation, (b) You were determined to be delinquent or to be a child in need of services, which did not result in a complaint transferred to Superior Court for criminal prosecution, or (c) Your crimes were misdemeanors and they occurred five or more years ago.
Note: A conviction record will not necessarily be a bar to volunteer service. Have you been convicted of a felony or misdemeanor? ☐ Yes ☐ No
[If yes, attach details including date, location (city), nature and offense and disposition.]

I certify that the statements made in this application are true and correct and have been given voluntarily. I understand that I will not be paid for my services as a Council Member of the Patient and Family Advisory Council. I agree to abide by the guidelines of the Patient and Family Advisory Council, to respect patient confidentiality, and to uphold the traditions and standards of Milford Regional Medical Center. I understand that membership on the Family Advisory Council will be based upon approval from Occupational Health Services, Council Co-Chairs and Program Manager. Professional staff will choose council members they feel are best suited for the Advisory Councils based on interviews and group consensus. Council members will demonstrate a readiness to help others, maintain respect for collaboration and assist Milford Regional Medical Center in delivering quality patient care.

I also understand that membership on the Council requires my commitment to at least attend a monthly Council meeting.

Applicant's Signature ____ Date ______________________

For those applying as a family member: To assure compliance with Federal HIPAA regulations, family members must include patient's name and obtain his/her signature to indicate that s/he understands you may use his/her name and/or medical history in your capacity as a PFAC member.

Patient Name: ____ Date: ____________________

Patient Signature: ____

Please return completed application to:

Patient and Family Advisory Council Office
Attn: Michelle Barry
14 Prospect Street
Milford, Massachusetts 01757
Or email to *michbarry@milreg.org*
(508) 422-2648