Baystate Health

ADVANCING CARE. ENHANCING LIVES.

Membership Application
Patient and Family Advisory Council

Please PRINT all information clearly.

Name:

Address:

Telephone number (s): Please indicate your preferred phone number and the best time to reach you:

Work: _____ Home: _____ Cell: _____ Fax:_____

Email address: Time preferred: AM: PM:

Please indicate if you are willing to share your contact information with other members? ☐ Yes ☐ No

Please check all that apply: I am the ☐ Patient/Parent ☐ Spouse/significant other ☐ Other ☐ Caretaker

I/my family have been treated at Baystate Health since ☐ *(year)*

Additional Language (s) spoken _____

Please tell us which service(s) you/your loved one have used in the last two years

_____

Please tell us which activities you might be interested in:

- ☐ Reviewing policies/procedures
- ☐ Planning for the hospital care experience
- ☐ Ensuring patient safety and the prevention of medical errors
- ☐ Developing/reviewing educational materials
- ☐ Educating and training providers, employees and other staff about the experience of care and effective communication support
- ☐ Improving the coordination of care and transition to home and community care
- ☐ Long-term advisory council membership to have impact and influence on policies and practices that affect the care and services patients and families receive
- ☐ Issues of special interest (please describe): _____

_____

Please indicate if you are willing to participate In-person or Virtual Only? ☐ In-person ☐ Virtual Only

Please tell us why you are interested in joining the Patient and Family Advisory Council:

_____

_____

Baystate Health believes incorporating diversity and inclusion within the Patient Family Advisory Council is an important aspect in this partnership.

Please share anything about yourself that you think would add to the diversity of the council:

_____

_____

Do you have any special skills or talents you believe will add value to the council? Please describe:

_____

_____

If you have served as an advisor, been an active volunteer committee member or have experience with public speaking for other programs or organization, please briefly describe this experience:

_____

_____

☐ Yes ☐ No Are you able to attend regularly scheduled monthly meetings?

☐ Yes ☐ No If applicable, are you willing to provide immunization records to serve on the Patient and Family Advisory Coucil?

☐ Yes ☐ No Are you willing to sign an agreement promising not to disclose confidential information given to you in your roles as a member of the Patient and Family Advisory Council?

☐ Yes ☐ No Are you willing to undergo a background check? The background check will include a social security trace and a criminal background check. It will not include a credit report. You have the right to obtain a copy of the report we receive.

Name (signature)_____ Date:_____

I am most interested in (select one):

- Baystate Medical Center (BMC) Adult Patient Family Advisory Council ☐
- Baystate Children's Hospital Patient family Advisory Council ☐
- BMC Emergency Department Patient Family Advisory Council ☐
- Baystate Franklin Patient Family Advisory Council ☐
- Baystate Noble Patient Family Advisory Council ☐
- Baystate Wing Patient Family Advisory Council ☐

Please submit completed application to: Jessica.Polito@baystatehealth.org 413-794-5656