Patient Family Advisory Board Application

Date: _____
Name: _____
Home Address: _____
Daytime Phone: _____ Best day/time to call: _____
Evening Phone: _____ Best day/time to call: _____
Email Address: _____

CHILDREN

Name: _____
Birth Date: _____
Has he/she been a patient at MCCH? _____Y _____N

Name: _____
Birth Date: _____
Has he/she been a patient at MCCH? _____Y _____N

Name: _____
Birth Date: _____
Has he/she been a patient at MCCH? _____Y _____N

Name: _____
Birth Date: _____
Has he/she been a patient at MCCH? _____Y _____N

Within the past two years have you used any of the following services at MCCH?
(Check all that apply)

☐ Emergency Department
☐ Pediatric Inpatient
☐ Pediatric Intensive Care Unit/Congenital Heart Surgery Unit
☐ Neonatal Intensive Care Unit
☐ Lab
☐ Radiology (X-ray), MRI, CT scan)
☐ Pediatric Day Surgery
☐ Pediatric Outpatient Clinic
☐ Other: _____

This section is optional. The questions are designed to help us make our committee as diverse as possible.

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino

Race:
☐ American Indian/Alaskan
☐ Asian
☐ Black
☐ White
☐ Other: _____

REFERENCE

Please include the name of a MCCH staff member who may be able to provide a reference for you (doctor, nurse, social worker, Child Life Specialist, medical family therapist, guest relations representative, housekeeper, physical therapist, etc).

Name: _____ Department: _____

I give permission to the MCCH Family Advisory Board nominating committee to discuss my application with the above reference.

Signature: _____ Date: _____

TELL US MORE ABOUT YOURSELF & YOUR EXPERIENCE

Why would you like to be involved in the MCCH Family Advisory Board?

We believe the Medical City Children's Hospital Family Advisory Board should reflect the cultural diversity of families who are consumers of hospital services. Please share anything about your family that you think would add to the diversity of this program. You might consider your diversity to be: ethnic, racial, spiritual, social, economic, educational, geographic, gender, sexual orientation, unique family structure, disability related, chronic illness, single parent, full time parent, grandparent, etc.

Is there anything else you would like us to know?

If you need additional room for any of the questions feel free to attach another sheet.

I understand that completion of this application does not bind the applicant or the program coordinators in any way. The MCCH Family Advisory Board reserves the right to choose participants that best meet the needs of the program. Before participating in the Family Advisory Board you will be asked to sign a confidentiality agreement.

Signature: _____Date: _____

Thank you for your time and interest. If you have any questions please feel free to contact Seana George, Patient Advocate Manager, by phone at 972-566-6710 or email at Seana.GeorgeTrujillo@MedicalCityHealth.com.

You may also fax your application to 972-566-6489.

Please mail forms to:
Seana George, Patient Advocate
Medical City Children's Hospital
7777 Forest Lane
Dallas, TX 75230