

Patient and Family Advisory Council Member Application

Thank you for your interest in the Patient and Family Advisory Council (PFAC). The PFAC was established to assist Central Texas Medical Center (CTMC) in delivering quality patient care by creating opportunities for ongoing input into the operation of the organization. Participation requires attendance to at least eight scheduled meetings per year. Meetings will be scheduled for a recurring date/time for majority attendance, and team member flexibility is greatly appreciated.

Inquiring Individuals must:

- Complete this application
- Attend a mandatory volunteer orientation, and
- Agree to the Health Insurance Portability & Accountability Act (HIPAA) and confidentiality sign-off requirements

All of your information will be handled as confidential.

Please print:

Name: _____
(Last) (First) (MI)

Address: _____
City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (10 digits) _____ **Cellular Phone:** (10 digits) _____
Work Phone: (10 digits) _____ **Fax:** (10 digits) _____

E-mail Address: _____
Language(s) You Speak: _____

Will you allow your contact information to be shared with other committee/advisory council members? (Fill-in choice)

- Yes
- No

I am: (fill-in all that apply)

- A patient
- A family member of a patient
- A staff member of CTMC
- Other, please specify: _____

Please list times when you are able to attend meetings: (fill-in all that apply)

- Daytime: _____
- Evening: _____
- Weekend: _____

The care provided and/or my experiences at Central Texas Medical Center were: (fill-in all that apply)

- Hospitalization (inpatient): MM/YY
- Clinic visit (outpatient): MM/YY
- Emergency Department care: MM/YY
- Other programs, departments, or services: MM/YY

I would be interested in helping to improve: (fill-in all that apply)

- Patient and family satisfaction tools
- Patient educational materials
- The hospitalization care experience (room, coordination of care, communication, food, etc.)
- The care systems and facilities for the outpatient and/or surgical experience
- The clinic (outpatient or ambulatory) care experience
- The care systems and facilities for the emergency care experience
- Patient safety and the prevention of medical errors
- Education of medical students and residents, new employees and other staff about the experience of care and effective communication and support.
- Facility design planning and way-finding
- The coordination of care and the transition to home and community care.
- Issues of special interest (please describe):

- I certify that the information given in this application is true and correct and given voluntarily.
- I agree to abide by the volunteer policies and guidelines of CTMC.
- I understand that all information I may gain, directly or indirectly, concerning a patient, physician, or any other person is to be kept confidential. Failure to do so may result in termination as a volunteer member of the CTMC Patient and Family Advisory Council.
- I authorize the staff of the PFAC to discuss my participation on the Council with associated clinical care staff including nurse and/or social worker, if applicable.

In signing below, I understand and accept the above statements.

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 he/she understands you may use his/her name and or medical history in your capacity as Council member.

Patient Name: _____
Patient Signature: _____ Date: _____

Please return completed application via email or in the enclosed return envelope to:

Ashleigh Arnett
Patient Experience Coordinator

Central Texas Medical Center
1301 Wonder World Dr.
San Marcos, TX. 78666

Tel: (512) 756 – 3526
Fax: (512) 753 – 3693
Email: ashleigh.arnett@ahss.org