

## Patient Family Advisor Application Form

Name (First and Last)

Street Address

City

State

ZIP Code

Home Phone

Cell Phone

E-mail Address

Preferred contact  
(check one)

Home phone

Cell Phone

E-mail

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### **The following questions will help us get to know you better.**

1. Are you a...

Patient

Family member of a patient

2. When was your care experience at this hospital? (Check all that apply)

2015-current

2010-2014

2009 or before

3. Which area(s) provided care for you or your family member: (check all that apply)

Hospital

Emergency Department

Rural Health Clinics (Bruning, Chester, Davenport, Deshler, & Hebron)

Specialty Clinic

Surgery

Lab

Radiology

Physical, Occupational or Speech Therapy

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### **Please tell us about yourself**

4. Are you available to serve as an advisor for at least one (1) year?

Yes

No

5. Why do you want to become a patient family advisor?

6. What issues are of special interest to you?

**Do you know of other individuals and families who have experienced care at Thayer County Health Services who might be interested in serving as advisors?**

**Please call them for us or list names, phone numbers, and email addresses below:**

Name, phone number and email address

Name, phone number and email address

**Thank you for your interest in becoming a Patient Family Advisor!**