ADVOCATE CHILDREN'S HOSPITAL

FAMILY ADVISORY COUNCIL APPLICATION

Name of applicant(s): _____ **Phone(s):** _____

Preferred contact person (if applying as a couple): _____

Home address: _____

City, State, ZIP: _____ **Best times to reach you:** _____

Email(s): _____ **Preferred method of contact:** _____

Occupation(s): _____ **Languages spoken at home:** _____

How did you hear about this opportunity? _____

Name of child or children with health needs or experience: _____

Date of birth: _____ **Relation to you:** _____

Primary diagnoses: _____ **Dates of first and last admission:** _____

Other children? ☐ Yes *(please enter names and dates of birth)* ☐ No

_____

_____

Would you be able to participate in monthly meetings for a term of two years? ☐ Yes ☐ No

Family Advisory Council takes place the fourth Monday of every month from 6:30 – 8:30 p.m.

Which Advocate Children's Hospital service has your family used? Please check all that apply. Check Past year if you have used the service within the past year or Ever received, if you have ever used the service.

We have received most or all services at Advocate Children's Hospital in: ☐ Oak Lawn ☐ Park Ridge ☐ Both

Past year	Ever received	Services
		2-Hope (Oak Lawn)
		4-Hope (Oak Lawn)
		2-Center (Park Ridge)
		2-West (Park Ridge)
		2-Tower (Park Ridge)

continued on next page

Advocate Children's Hospital®

Past year	Ever received	Services
		5-Child & Adolescent Behavioral Health Services, inpatient and partial hospital (Park Ridge)
		Asthma or allergy
		Cardiology
		Cath or electrophysiology labs
		Developmental clinic
		Ear, Nose & Throat (ENT)
		Endocrine or diabetes
		Gastroenterology
		Genetics
		GI lab
		Hematology or oncology
		Nephrology
		Neurology
		Neurosurgery
		Newborn Intensive Care Unit (NICU)
		Orthopedics
		Outpatient clinic; please specify:
		Outpatient lab
		Outpatient surgery
		Pain team
		Palliative care
		Pediatric Emergency Department
		Pediatric Intensive Care Unit (PICU)
		Busking Family Pediatric Cardiac Intensive Care Unit (Oak Lawn)
		Pediatric therapies (physical therapy, occupational therapy, speech, swallow studies, audiology)
		Psychology or psychiatry
		Pulmonology
		Radiology (X-ray, MRI, CT, IR, ultrasound)
		Respiratory
		Surgery
		Urology
		Other; please specify:

Tell us about yourself and your family: _____

Advocate Children's Hospital®

Why would you like to be a member of the Family Advisory Council?*

_____

_____

_____

_____

_____

What do you feel you could bring to the Family Advisory Council?

_____

_____

_____

_____

_____

*Please be aware that the Family Advisory Council is not a support group. It is a working group to support patient and family-centered care.

Conditions of volunteer services (*please read before signing*):
We will contact you by phone or email if you are selected for an on-site interview to learn more about your interests, and discuss the opportunity to become a member of the Family Advisory Council. To participate, you must meet our standard volunteer requirements. You will be required to pass a criminal background check, submit immunization records and receive any necessary immunizations, undergo HIPAA training and sign a confidentially agreement. If you are unable to fulfill these requirements, you will not be eligible to serve on the Family Advisory Council.

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 volunteer member of the Patient and Family Advisory Council. I agree to abide by the guidelines of Volunteer Services, to respect patient confidentiality, and to uphold the standards of Advocate Children's Hospital. All information contained on this form is considered confidential and is intended for use by the Advocate Children's Hospital Family Advisory Council Selection Committee only.

Applicant's signature:_____ Date: _____

Please save and email completed application to: ACH-FAC@aah.org

Advocate Children's Hospital®