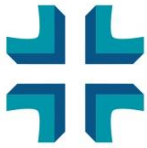

Patient Family Advisory Council

Membership Application

Date: ________________

CONTACT INFORMATION

Name: ____

Mailing Address: ____

City: ____________________________ State: __________________ Zip Code: _________________

Phone Number: ___________________ E-Mail Address: ____________________________________

How do you prefer to receive communication about the council?
☐ Mail ☐ E-Mail

May we share contact information with other council members?
☐ Yes ☐ No

Have you received care at a hospital or clinic for which this council is being formed?
☐ Yes ☐ No
If Yes, name of hospital and/or clinic: ____

Do you have any dietary needs we should be aware of? (i.e., vegetarian, food allergies)
☐ Yes ☐ No
If Yes, please elaborate: ____

Do you have any special needs we should be aware of?
☐ Yes ☐ No
If Yes, please elaborate: ____

Why are you interested in being a member of the Patient Family Advisory Council?

____
____
____

What issues would you like to see the council address?

____
____
____

What special interest or experiences would you like to offer to our council?

____
____
____

Contact person: Kimberly Burgess
Email application to: kimberly.burgess@prowersmedical.com
Mail application to: 401 Kendall Drive • Lamar, CO 81052 **Phone number: 719.336.7391**