



PATIENT AND FAMILY ADVISORY COUNCIL
Member Application

Date: _____

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Phone: _____

Email Address: _____

1. What is your preferred way of receiving communication about the council?
 Email Regular mail
2. Is it okay to share your contact information (address, telephone number, and email address) with other members of the council?
 Yes No
3. Have you received care at a clinic or hospital in the Tift Regional Health System?
 Yes No
If yes, at which clinic or hospital did you receive care: _____

4. Do you have any dietary needs we should be aware of (i.e. vegetarian)?
 Yes No
If yes, please elaborate: _____

5. Do you have any special needs we should be aware of?
 Yes No
If yes, please elaborate: _____

6. Why would you like to be on the council?

7. What issues would you like to see the council address?

8. What special interest or experiences would you like to offer to the council?

