Yale NewHaven Health

Patient and Family Advisory Program Application

Thank you for your interest in the Patient and Family Advisory Program

NAME AND ADDRESS							
Last Name		First name		M.I.	Today's date		
Street Address				Apartment/Unit #			
City		State		ZIP			
Phone		E-mail Address					
Cell		Preferred Contact:	Phone ☐	Cell ☐	E-mail ☐		
Demographic Information:	Date of Birth		Gender	Level of Education			

Location you're interested in serving:

- ☐ Bridgeport Hospital (Bridgeport or Milford campuses)
- ☐ Greenwich Hospital
- ☐ Lawrence + Memorial Hospital
- ☐ Northeast Medical Group (NEMG)
- ☐ Westerly Hospital
- ☐ Yale New Haven Hospital

ABOUT YOU *Help us get to know you better*

Are you a…	☐ Family member of a patient ☐ Patient	When was your care at Yale New Haven Health?	State the year_____
What areas provided care to you or your family?	☐ Emergency Department ☐ Inpatient units ☐ Outpatient Clinics ☐ Diagnostic Imaging ☐ Laboratory Services ☐ Hospice ☐ Ambulatory Surgery ☐ Walk-in/Urgent Care		
How much time are you able to commit to being a patient and family advisor?	☐ 2-4 hours per month ☐ More than 4 hours per month ☐ 1-2 hours per month ☐ 1 hour per month		
Are you available to be an advisor for at least 1-2 years?	☐ Yes ☐ No		

ABOUT YOUR EXPERIENCE – WHY DO YOU WANT TO BECOME AN ADVISOR?
Please share how these experiences influence your interest in the Patient and Family Advisory Program.

SIGNATURE

I have provided complete and accurate information in this application for a patient and family advisor position in the Yale New Haven Health System. I further acknowledge that falsification or omission of any significant information presented or requested on this application or during the interview process may result in rejection for a volunteer position or dismissal. I hereby authorize Yale New Haven Health System to request information regarding my application for volunteer work from the references I have provided. I authorize Yale New Haven Health System to take my photograph in relation to my volunteer position. For the safety of patients, their families, and hospital staff, the screening process for Yale New Haven Health System volunteer applicants over age 18 includes a comprehensive background check, to be conducted with your signed authorization, following your interview.

☐ I have read, understand, and agree to this statement.

Signature _____ Date: _____

How did you hear about the Patient and Family Advisory Program?

☐ Online

☐ Brochure

☐ Family Member

☐ Current Patient and Family Advisor: _____

☐ Staff: _____

☐ Other: _____

MAIL TO:

- Bridgeport Hospital (Bridgeport /Milford), Volunteer Services, 267 Grant Street, Bridgeport CT 06610
- Greenwich Hospital Patient and Guest Relations, 5 Perryridge Road, Greenwich CT 06830
- Lawrence + Memorial/Westerly Hospital, Patient Relations Dept., 365 Montauk Ave, New London, CT 06320
- Northeast Medical Group Business Office, Patient Experience, 9 Washington Ave 2nd floor, Hamden CT 06518
- Yale New Haven Hospital, Volunteer Services Department, 1450 Chapel St., New Haven CT 06511