Thank you for your interest in serving on our Patient and Family Advisory Council for UF Health. Our Patient and Family Advisors make invaluable contributions by sharing their time, perspectives, insights and experiences with our organization to help us to improve our health care services, practices and facilities. Patient and Family Advisors and work side-by-side with UF Health staff on committees and in work groups to identify service, communication and facility issues, brainstorm unique solutions and help us implement change or improve processes.

Please complete and return this application if you are:

- interested in actively partnering with UF Health to improve clinical quality, patient safety and the overall experience of patients and families;
- committed to promoting a patient-centered approach to all interactions across UF Health;
- able to make a six-month commitment (minimum) to serve on a process improvement team, committee or advisory group; and
- able to express constructive criticisms and positive suggestions.

If we have an opening that matches your interests we will discuss specifics such as meeting times and locations. Please note that not all Advisory Council activities require on-site participation and we do our best to match participants’ interests and schedules to our activities.

Thank you! We look forward to reviewing your application and considering you for this role.

To learn more about how health care organizations across the country are building partnerships between health care providers and their patients visit the Institute for Patient and Family Centered Care at www.ipfcc.org

We sincerely appreciate your interest!

The Patient Experience Team
UF Health Sebastian Ferrero Office of Clinical Quality and Patient Safety
Patient & Family Advisory Council
Member Application

Your Name: ______________________________________________________________

Street Address: ____________________________________________________________________________

City: __________________ State: _______ Zip Code: __________

Home Phone: _______________ Cell Phone: _______________

E-mail: __________________________________________

Within the past two years, have you/has your loved one used any of the following UF Health services? (Check all that apply)

☐ Emergency Room (Adult) ☐ Pediatric Emergency Room ☐ Adult inpatient
☐ Outpatient Clinic ☐ Pediatric inpatient ☐ Lab
☐ Surgery ☐ X-ray
☐ Other (please explain): ____________________________________________________________

Within the past two years, have you/has your loved one used other UF Health services? (Check all that apply)

☐ UF Health Shands Rehab Hospital
☐ UF Health Physicians outpatient specialty medical practices
☐ UF Health Shands HomeCare
☐ Other (please explain): _____________________________________________________________

Please share some things your care team did or said that made your family’s experience at UF Health more pleasant and easier for you?

____________________________________________________________________________
____________________________________________________________________________

Please share some things your care team did or said that made your family’s experience at UF Health more difficult?

____________________________________________________________________________
____________________________________________________________________________

Please explain why you are interested in joining the UF Health Shands Hospital Patient & Family Advisory Council:

____________________________________________________________________________
____________________________________________________________________________
Patient & Family Advisory Council
Member Application

Please describe other committee or volunteer experience you have had (schools, community, churches, etc.).
____________________________________________________________________________
____________________________________________________________________________

We believe the UF Health Shands Hospital Patient and Family Advisors should reflect the cultural diversity of our patients and families and the communities we serve. Please share anything about yourself that you think would contribute to the diversity of our program. Please consider diversity to be any of the following or more: ethnicity, race, age, spiritual or religious background, economic background, education, geographic experience, gender, sexual orientation, family structure, and/or language(s) spoken, etc.
____________________________________________________________________________
____________________________________________________________________________

Is there anything else that you would like us to know? (Please feel free to use additional pages.)
____________________________________________________________________________
____________________________________________________________________________

References (optional):
If you were referred by a UF Health employee, please include their name below. We’d like to thank them for referring you. If you would like to provide additional references, please attach an additional page.

Name: ____________________________ Department: ____________________________

Applicant Agreement:
I understand that completion of this application does not bind the applicant or the program coordinators in any way. UF Health reserves the right to choose participants that best meet the needs of the organization. Before participating, I understand that I will be asked to sign a confidentiality agreement.

Signature: _________________________ Date: ____________

Thank you for taking the time to tell us about your interest in the UF Health Patient Advisory Council. Please return your application to:
Christine Cassisi, Director, Patient Experience
UF Health Office of Quality & Patient Safety
P.O. Box 100338, Gainesville, FL 32610-0338
Phone: 352-265-8034 Email: CASSCM@shands.ufl.edu Fax: 352-265-0639