My Participation Interests

Contact Information

Name (First and Last): ___________________________________________________________________________________

Street Address: ________________________________________________________________________________________

City: _________________________________ State: __________________________ ZIP Code: _____________________

Home phone:________________ Cell phone: __________________ Email address: _______________________________

Preferred contact (circle one): Home phone Cell phone Email

Areas of Interest

I am interested in receiving more information on the following activities (please check all that apply):

[NOTE: Edit the list below as appropriate for your hospital’s priorities.]

- Helping to develop or review informational materials for patients and family members
- Providing feedback on and helping to improve hospital policies, staff and clinician practices, programs, or facility design
- Helping to educate or train hospital staff, clinicians, and trainees by sharing your story
- Sharing my story with health care providers or others
- Serving as a member of the patient and family advisory council
- Serving on [insert name of committee]
- Other:___________________________________

Thank you for your interest. Please return this form to:

[Insert hospital name, staff liaison name, and email and phone contact information]