Patient and Family Advisory Council
Application for Membership

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Name: _____

Address: _____

City/State/Zip Code: _____

Preferred phone number: _____-_____-_____ ☐Work ☐Home ☐Cell Best time to call: _____

Email address: _____

Please respond briefly to the questions below.
You will have an opportunity to elaborate further later in the process.

1) Are you a former patient of one of McLean Hospital's various psychiatric programs? If so, how recently did you receive care at McLean and at what program(s)?

2) Are you a family member of a patient who received direct care from McLean Hospital? Were you involved in your family member's care? If so, how recently?

3) How would you describe your experience as a patient, or family member of a patient, at McLean Hospital?

4) What prompted your interest in serving on this committee?

5) What unique perspective would you bring to the Council?

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Applicant's Particular Interests

I would be interested in helping to improve: (check all that apply)

- ☐ Patient and family satisfaction tools
- ☐ Patient educational materials
- ☐ The hospital care experience (room, food, physical plant)
- ☐ Education of medical students, residents, nursing students, social work interns, new employees, and other staff about the patient/family experience of care and effective communication and collaboration
- ☐ The coordination of care and the transition to an aftercare program
- ☐ Other

I certify that the statements made in this application are true and correct and have been given voluntarily. If selected, I understand that I will not be paid for my services as a volunteer member of the Patient and Family Advisory Council. I agree to abide by the guidelines of Volunteer Services, to respect patient confidentiality, and to uphold the traditions, values, and standards of McLean Hospital.

I understand that completion of this application does not bind me, the applicant, in any way. McLean Hospital reserves the right to choose participants that best meet the needs of the Patient and Family Advisory Council. Before participating in the Council, I understand that I will be asked to sign a confidentiality agreement.

Signature: _____ **Date:** _____

Received by: _____ **Date:** _____

Please tell us how you heard about this committee:

- ☐ Approached by McLean Staff
- ☐ Found application on unit
- ☐ Other _____

Please return application to:
Linda M. Flaherty, RN/PCNS
McLean Hospital
115 Mill Street
Belmont, MA 02478

All applications are reviewed by the PFAC interview team.