Bayfront Health Port Charlotte

2500 Harbor Blvd., Port Charlotte, FL 33952

Patient and Family Advisor Application Form

– Return to Deb Clark, Administration, 2500 Harbor Blvd Port Charlotte, FL 33952

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** ◯

1. **Are you a…**
   - ❑ Patient
   - ❑ Family member of a patient
2. **When was your care experience at this hospital? (Check all that apply.)**
   - ❑ 2016 to current year
   - ❑ 2015
3. **What language(s) do you speak?** _____
4. **We recognize that our patient and family advisors have busy lives. How much time are you able to commit to being a patient and family advisor? (Check one)**
   - ❑ Less than 1 hour per month
   - ❑ 1 to 2 hours per month
   - ❑ 3 to 4 hours per month
   - ❑ More than 4 hours per month
5. **Are you available to serve as an advisor for at least 1 to 2 years? (You can still be an advisor if you answer "no.")**
   - ❑ Yes
   - ❑ No

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Patient and Family Advisor Application Form (continued)

6. How do you want to help? I want to: (Check all of your interest areas)

- ❑ Serve as a member of the patient and family advisory council. Potential advisory council members should be ready to commit to serving on the council for at least 1 to 2 years. The advisory council meets once a month for 1 ½ to 2 hours.
- ❑ Help develop or review informational materials for patients and family members.
- ❑ Help improve patient safety and the prevention of medical errors from the patient perspective.
- ❑ Help improve the patient-and-family role in care decision-making.
- ❑ Help improve the hospital facilities

(for example, patient care areas, or family resource room).

- ❑ Help educate or train hospital staff and clinicians to be more aware of the patient perspective.
- ❑ Review procedures and provide input to improve the hospital admission process.
- ❑ Provide input as we discuss various topics, like bedside shift report, where nurses who are going off duty share information with nurses coming on duty at the patient's bedside.
- ❑ Review procedures and provide input to improve transitions in care (for example, between hospital units or discharge from hospital to home).
- ❑ Other issues (please describe): _____

_____

_____

_____

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Patient and Family Advisor Application Form (continued)

Please tell us about yourself.

7. **Why do you want to become a patient and family advisor?**

8. **Please briefly describe any experience you may have as an advisor, as an active volunteer, or as a public speaker.**

9. **Please describe any specific things that doctors or hospital staff did or said while you or your family members were in the hospital that were helpful to you or your family.**

10. **Please describe any specific things that doctors and hospital staff could have done differently to be more helpful while you or your family member were in the hospital.**

11. **Our patient and family advisors reflect the diversity of the patients and families we serve. Please share anything about yourself that you think would add to the diversity of our team of advisors.**

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Patient/Family Advisory Council Confidentiality Agreement

I understand that, as a volunteer participant on the Patient/Family Advisory Council ("PFAC"), I may be exposed to confidential information. I also understand patients, visitors, employees and other individuals associating or interacting with the hospital or health care facility have the legal right to confidential treatment of their information.

Therefore, any and all information I am exposed to within the course of my interactions with the PFAC shall be treated as confidential information. Confidential information includes, but is not limited to, protected health information ("PHI") as regulated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). PHI includes any information about a patient's visit, including but not limited to a patient's name, address, phone number, date of birth, financial information, diagnosis, and treatment. I agree to not disclose any confidential information revealed during a PFAC meeting to anyone outside of these sessions.

The easiest way to remember what this agreement means is the saying, "<u>What you hear or see here must remain here</u>."

Information discussed by participants during the PFAC sessions should not include more information than is necessary. Examples include, but are not limited to:

Patient/Family members must not mention other patients or families by name or by any other identifying information.

Patient/Family members should avoid mentioning specific doctors, employees, and staff members by name or any specific clinical outcomes that may have occurred.

Please sign below to let us know that you have reviewed this information, understand it, and agree to it. Signing your name means that you have read and understood the information above, that you have had a chance to ask questions, and that you agree not to share any confidential information outside the hospital or health care facility in any written, verbal, or electronic communications.

You further acknowledge that you understand if you violate this agreement you may be required to take additional training or your participation as a volunteer participant may be revoked.

Name (please print) _____

Signature _____

Date _____