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]

 **Guide to Patient and Family Engagement**