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]