Date:

PATIENT & FAMILY ADVISORY COUNCIL

VOLUNTEER APPLICATION

APPLICATIONS ARE DUE BY JUNE 14, 2024

PERSONAL INFORMATION

Full Name (First, MI, Last):

Email Address:

Phone Number: ( )

Are you 18 or older? ☐ No ☐ Yes

Home Address:

City: State: Zip Code:

Is your home address the same as your mailing address? ☐ No ☐ Yes

- If No, specify mailing address:

Length of Residence in Pend Oreille County or Bonner County:

OPTIONAL INFORMATION

We want to make sure this council represents our entire community.

Age: ☐ Choose not to disclose.

Groups you identify with:

Race: ☐ Choose not to disclose.

Ethnicity (check one): ☐ Choose not to disclose.

Sexual orientation: ☐ Choose not to disclose.

Gender: ☐ Choose not to disclose.

Do you have a Federally-recognized disability? ☐ No ☐ Yes ☐ Choose not to disclose.

OCCUPATION & EDUCATION INFORMATION

Occupation:

Are you retired? ☐ No ☐ Yes

Are you or any of your familiy members employed by NHHS? ☐ No ☐ Yes

Are you a veteran? ☐ No ☐ Yes

Are you a homemaker? ☐ No ☐ Yes

Are you currently unemployed? ☐ No ☐ Yes

Are you a student? ☐ No ☐ Yes

- If Yes to any of the above, please specify previous occupation:

Highest Level of Education attained:

Why do you want to serve on the Patient & Family Advisory Council?

Days/times you are unavailable?

SIGNATURE

Applicant Signature

By signing, I attest that I have answered truthfully to the best of my knowledge. I understand that if I'm chosen to join the Council, I will be required to undergo a Washington State Patrol background check, sign confidentiality agreements, and adhere to HIPAA / privacy standards. I also understand this is a volunteer position, and I will not be paid to participate.