UCSF Benioff Children's Hospital Oakland

Family Advisory Council
UCSF Benioff Children's Hospital Oakland
Application Form

We would appreciate your assistance in completing this form if you are interested in serving as a member of our Family Advisory Council, other advisory team, or improvement team. Information provided is confidential and will not affect the care being provided to your family member(s). This committee meets twice a month, 1st Tuesday of the month at 6:30pm and the 3rd Thursday of the month at 10:00 am.

Name: _____ **Home Phone:** _____

Address: _____ **Work/Cell Phone:** _____

City/State/Zip: _____ **Email:** _____

What is the best way to contact you and when? _____

How are you interested in supporting the hospital Family Advisory Committee?

____Attend regular monthly meetings

____Participate in special teams or special projects

Thank you for taking the time to complete this application to become a family advisor for UCSF Benioff Children's Hospital Oakland. Please answer the following questions:

1. **Why are you interested in partnering with the hospital as a family advisor?**

2. What patient care experience have you had at our hospital during the past five (5) to seven (7) years?

3. How would you describe your overall patient care experience?

4. Is there anything else you would like to add?

_____ _____

Signature: Date:

All information contained on this form is considered confidential and is intended for use by UCSF Benioff Children's Hospital Oakland Family Advisory Selection Committee only. You will be contacted upon receipt of this application form to participate in a face-to-face interview. If selected, all Family Advisor applicants must pass a background check and complete a health screening.

Thank you! Please email this document to cjohnston@mail.cho.org, fax it to **510-601-3924**, or mail to:

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