UCSF Benioff Children's Hospital San Francisco

Family Advisory Council

Application for Family Members

Today's Date: _____

Welcome! Thank you for your interest in joining the UCSF Benioff Children's Hospital Family Advisory Council. We believe the family perspective is essential to providing quality care for children and their families and our family advisory council plays an integral role in patient satisfaction efforts.

Expectations of ACTIVE FAC members – Attends monthly meetings on a regular and consistent basis. May hold officer and/or leadership position. Provides education on parent panels and/or support at Peer-to-Peer Parent Support Events. May also hold membership on UCSF Benioff Children's Hospital committees.

Please take a moment to fill out the following application and let us know what areas of focus interest you most.

Name: _____
(Please Print)

Home Address: _____

_____

County: **_____Cell Phone Number: (____)_____**

E-mail Address: _____

Children:

1. **Name: _____ Birth Date: _____**

   Does your child have special needs? ❑ Yes ❑ No
   Has he/she been a patient at UCSF BCH, San Francisco? ❑ Yes ❑ No

2. **Name: _____ Birth Date: _____**

   Does your child have special needs? ❑ Yes ❑ No
   Has he/she been a patient at UCSF BCH, San Francisco? ❑ Yes ❑ No

3. **Name: _____ Birth Date: _____**

   Does your child have special needs? ❑ Yes ❑ No
   Has he/she been a patient at UCSF BCH, San Francisco? ❑ Yes ❑ No

Information Form for Family Members:

What services at UCSF Benioff Children's Hospital, San Francisco have you used with your child?

- ❑ **Emergency Room**
- ❑ **Outpatient Clinic**
- ❑ **Children's Surgery Center**
- ❑ **Inpatient (please check all units you have been in with your child)**

Hem/Onc____BMT___ Med/Sur___Transitional Care___ PICU___CTCU___CICU___ICN___

- ❑ **Radiology**
- ❑ **Lab**
- ❑ **Integrated Peds. Pain & Palliative Care**
- ❑ **Other _____**

This section is optional. The questions will help us make our council as diverse as possible:

Ethnicity:

- ❑ **Hispanic/Latino**
- ❑ **Non Hispanic Latino**

Race:

- ❑ **American Indian**
- ❑ **Asian**
- ❑ **African American**
- ❑ **White**
- ❑ **Other _____**

Primary Language Spoken:

What other language (s) do you speak (Check all that apply)

- ❑ **American Sign Language**
- ❑ **English**
- ❑ **Spanish**
- ❑ **Cantonese**
- ❑ **Other _____**

Reference:

Please include the name of a UCSF Benioff Children's Hospital staff member with whom you have worked (doctor, nurse, social worker, child life specialist, case manager, housekeeper, physical therapist, etc.)

Name: _____ Department: _____

Tell Us More about Yourself and Your Family Experience

The Family Advisory Council provides input, education, parent-to-parent support, hospital wide committee representation.

How would you like to be involved on the Family Advisory Council?

_____

_____

_____

_____

We believe the Family Advisory Council should reflect cultural diversity of families who are consumers of UCSF Benioff Children's Hospital Services. Please share anything about your family that you think would add to the diversity of this program. You might consider your diversity to be ethnic, racial, spiritual, social, economic, educational, geographical, gender, sexual orientation, unique family structure, disability related, chronic illness, single parent, full time parent, grandparent, etc.

_____

_____

_____

_____

_____

Is there anything else you would like us to know?

_____

_____

_____

_____

_____

Please feel free to attach another sheet if necessary.

_____ _____

Signature **Date**

Thank you for your time and interest. If you have any questions, please feel free to contact Becky Higbee Sumner (415-353-1410). becky.higbee@ucsf.edu

Please mail this information form:

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Family Advisory Council
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