Patient and Family Advisory Council Application

Date: _____

Name: _____

Mailing Address: _____

Street: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Current or Prior Employment Experience: _____

1. What is your preferred way of receiving communication about the council?
   _____Email _____Regular Mail _____Cell Phone _____Home Phone
2. Is it OK to share your contact information (address, telephone number and email address) with other members of the council? _____Yes _____No
3. Have you received care at Wyoming Medical Center in the past year?
   _____Yes _____No
4. Do you have any special needs we should be aware of? _____Yes _____No
   If yes, please elaborate. _____
5. Why would you like to serve on the council? _____
   _____
   _____
   _____
6. What experience(s) have you or your family member had at WMC? _____
   _____
   _____
   _____
7. What issues would you like to see the council address and what ideas do you have?
   _____
   _____
   _____

8. What special interest or experiences would you like to offer to the council?

   _____

   _____

   _____

9. What personal strengths do you believe would be useful to the council?

   _____

   _____

   _____

10. Do you have experience working collaboratively with others on projects? If so, please describe.

    _____

    _____

    _____

11. Please list any volunteer work, committees or organizations you have been involved with and describe your role and responsibilities.

    _____

    _____

    _____

12. What is the best day and time for you to meet? _____

    _____

_____ _____

Signature Date

Please return your completed application to:

Mandy Cepeda
Wyoming Medical Center
Community Development
1233 E. Second St.
Casper, WY 82601

For questions:
(307)577-2410
mcepeda@wyomingmedicalcenter.org