

## PATIENT AND FAMILY PARTNERSHIP COUNCIL MEMBERSHIP APPLICATION

Thank you for your interest in becoming a member of the Patient Advisory Council (PFPC) at Long Island Jewish Medical Center. Please complete the below information so we can get to know you better.

**Please PRINT Clearly:**

**Name:**

**Address:**

**Telephone Number (s): Please indicate preferred phone number and best time to reach you:**

**Work:**

**Home:**

**Mobile:**

**Email:**

**Languages you speak:**

**Why would you like to be a member of the Patient Advisory Council?**

**List health care services you have used or areas of special interest:**

**What else would you like us to know about you?**

**Will you allow your contact information to be shared with other Council members?**

Yes  No

**What times are you able to attend meetings/events:** (check all that apply):

Mornings  Afternoons  Evenings

**What days of the weeks are best for you?** (Check all that apply):

Monday  Tuesday  Wednesday  Thursday  Friday

**Commitment Interest:**

I am interested in a **2 year** commitment to the Patient Advisory Council.

I am interested in participating in a short-term project or panel.

I understand that volunteer membership on the Patient and Family Partnership Council will be based upon approval by the PFAC Council.

**Applicant's Signature**

**Date:**

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\*Please email this completed application to the Patient & Family Centered Care Department Manager, Michelle Rossetti at [mrossetti1@northwell.edu](mailto:mrossetti1@northwell.edu). Questions? Please contact 718-470-8785.

