Beverly Hospital
A member of Lahey Health
Addison Gilbert Hospital
A member of Lahey Health

PATIENT/FAMILY ADVISOR VOLUNTEER APPLICATION

Addison Gilbert Hospital (AGH)
Beverly Hospital (BH)

Patient Experience
85 Herrick St., Beverly, MA 01915
(978)922-3000 x3407

Personal Data

Name _____
first last

Address _____
street city state zip

Home Phone ( )_____ Work Phone ( ) _____

Email address _____Cell Phone ( )_____

Emergency Contact _____( ) _____ _____
name phone number

We seek a diverse representation of patient experiences and ask that you voluntarily provide the following information:

Gender _____ Age_____ Race_____ Religion_____

Ethnicity_____ Special Needs (Deaf, HOH, Blind)_____

Languages _____

Can we share your contact information with other Patient/Family advisors? Y___ N ____

Hospital Care Experience

I am a patient/former patient. _____

I am a family member of a pt/former patient. ____ Relationship to pt _____

Dates of my care experiences:

Within the past year_____ Within the past five years_____

Other_____

What services have you and your family member used at BH/AGH within the past two years?

Emergency Dept _____ Radiology_____

Inpatient _____ Cardiovascular_____

Oncology Treatment_____ Maternity_____

Intensive Care _____ Ambulatory Surgery_____

Endoscopy _____ Medical Day Care_____

Pediatrics_____ Special Care Nursery_____

Areas of Interest

What activities would you be interested in helping with?

Developing/reviewing patient educational materials_____

Educating employees about the patient and family perspective _____

Serving on a hospital committee to improve patient safety and quality _____

Advisory Council membership to have influence and impact on policies and practices _____

Other areas of interest_____

Other skills

Describe why you would like to be a patient/family advisor.

Please write about the skills you have to offer (public speaking, volunteer committee work, etc.)

Availabilit

When are you available to attend meetings?

Daytime_____ Evenings_____

How much time per month can you volunteer?

_____

Statement of Understanding

-I affirm that the information provided on this application is true and complete.

-I understand if I am accepted, active volunteer status is contingent upon compliance with hospital policies and procedures and a mandatory health screening.

-I understand the Volunteer Services Department reserves the right to terminate my service as a volunteer.

-I understand I will not be compensated monetarily by the hospital for my volunteer services.

-I authorize the hospital to make any inquiries to determine my suitability for volunteering.

-I understand Criminal Offender Record Information checks are required for all volunteer applicants over the age of 18. (Copy of driver's license required –in person.)

Your Signature _____ Date_____

Personal References

Please *complete* all fields below: reference forms will be *emailed* whenever possible. PLEASE DO NOT USE RELATIVES AS REFERENCES.

1. Name_____
first last

Address _____
street city state zip

Email Address***(Please include)**: _____

Phone ( )_____ Relationship to Applicant_____

2. Name _____
First last

Address _____
street city state zip

Email Address***(Please include)**: _____

Phone ( )_____ Relationship to Applicant _____

For Office Use Only:

Information Meeting:

References Sent: ____

CORI Sent: _____

References Received:

Assignment:

Day: _____

Time: _____

Start Date:

TB read:

Kronos#:

Meal Voucher#:

For Office Use Only:

COMMENTS:

_____