



Family Advisory Council

Council Member Application Form

Thank you for your interest in becoming a council member on the Family Advisory Council. Please print clearly. This information is received in the strictest confidence. (We are parents, too!)

1. Name _____
Address _____
City, State, Zip _____
Daytime Phone _____ Evening _____
Cell _____ Email _____

2. Please briefly describe your child's medical story: (You may also add pages.)

3. We'd also like to know which parts of the hospital you are familiar with.

How many total days has your child spent as an in-patient? _____

How many times have you had clinic appointments? _____

How many times have you visited the Emergency Room? _____

4. Council members are often asked for advice from different departments and units within the hospital. From the list below, please pick those departments or units you are familiar with and could comment on.

Cardiac/ Cardiology

Emergency Room

GI/Liver

Medicine

Neurology

NICU

Oncology

Orthopedic

PICU

Psychiatry

Renal (Kidney related)

Surgery

Transplant

Other (Please indicate)

5. Council members on the Family Advisory Council work with hospital staff on a regular basis. Please explain why you think parents and staff working together on different projects is a good idea.

6. A diverse council is important to us. Please check the following that apply to you:
Then please add to the line below:

African-American Asian Latino Caucasian Other _____

7. Please tell us anything else about your family that would add to the diversity of the council. (language, religion, culture, family structure, etc.)

8. Have you ever volunteered for the hospital before?

9. How did you hear of us?

(mailing; brochure or flyer in the hospital; staff member referral; fellow parent; FAC council member, etc.)

10. Hospital Recommendation

We would like to ask a hospital staff member to support your application. Please give us the name of a doctor, nurse, child-life specialist, social worker, or any other staff member who would recommend you.

Name of Staff Member: _____

Phone/Pager: _____ Or email: _____

***Thank you for completing this application for the Family Advisory Council.
If your application is successful, you will be contacted for an interview.***

Please note: Council members are considered volunteers of the hospital and are subject to a background check by the hospital's Volunteer Services Department.

Apply online at www.childrensnyp.org or send the completed form to the Membership Officer by mail:

MSCHONY
3959 Broadway
CHS-117
NY, NY 10032