Patient Advisor Application

DATE: _____

Please print:

Name: _____ **Date of Birth**: _____
(Last) (First) (MI)

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: (____) _____ **Cellular phone:** (____) _____

E-mail address: _____

Will you allow your contact information (email and or phone number) to be shared with others:

Your Patient Advisory Council members	☐Yes ☐No
Patient Advisory Council members from other SFHN Health Centers	☐Yes ☐No
SFHN Primary Care staff and leaders	☐Yes ☐No

Please check all that apply:

I am: ☐A Patient ☐A Family member of a Patient

What times are you able to attend meetings/events:

☐Mornings ☐Afternoons ☐Evenings

What days of the weeks are best for you?

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Patient Advisor Commitment Interest:

☐ I am interested in a 1 **year** commitment to the Patient Advisory Council (PAC).

☐I am interested in participating in a short-term project or panel outside of the monthly PAC meetings.

Please share any skills, interests, experience or talents that you feel you can contribute to the Patient Advisory Council:

_____

_____

_____

Please fill out page 2 on back -->

DEMOGRAPHIC INFORMATION

What year did you become a patient of the San Francisco Health Network (clinic or hospital):_____

Primary Care Clinic (Health Center): _____

Primary Care Provider:_____

Race/Ethnicity: (please check one)

Asian	
South Asian	
Southeast Asian	
Pacific Islander	
Indígena	
Black/African American	
Hispanic/Latino	
Native Hawaiian	
Native American	
White	
Other (please specify)_____	

GENDER: _____

AGE: _____

Please select all the LANGUAGES you speak:

English	
Spanish	
Chinese	
Tagalog	
Russian	
Vietnamese	
American Sign Language	
Other (please specify) _____	

Signature: _____ Date: _____