COOLEY DICKINSON
HOSPITAL
MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

30 Locust St., PO Box 5001
Northampton, MA 01061-5001

Tel: 413-582-2000
cooley-dickinson.org

PATIENT AND FAMILY ADVISORY COUNCIL

Member Application Form – Patient or Caregiver

Date: _____

Name: _____

Mailing Address: _____

City: _____ State: _____Zip Code: _____

Telephone: (___)_____ E-mail Address:_____

1. What is your preferred way of receiving communication about the council? (Please choose one)

☐ Email ☐ Regular Mail

2. From which of the following sources did you learn about this opportunity? (Please choose one)

☐ Newspaper ☐ Radio ☐ Internet ☐ Health care practitioner ☐ Word-of-mouth ☐ Other (specify):

_____

3. Have you or a family member had a recent health care experience at Cooley Dickinson? (i.e., within the past 3 years)

☐ Yes ☐ No

- If yes, at which facility?

  _____

4. What diversity or unique viewpoint will you bring to the Council?

5. What do you want to achieve as a Council member? (Please provide a brief statement of intent)

Please complete this form fully and return it by mail or e-mail to:

Robin Kline, Director of Volunteer Services
rkline4@cooleydickinson.org
Cooley Dickinson Hospital
30 Locust Street
Northampton, MA 01061