



ProHealth Physicians Patient Family Advisory Council (PFAC) Application

Name: _____ Today's Date: _____
(please print)

Home Address: _____
(please print) (Street address) (town, state, zip code)

Phone: (_____) _____ Cell phone: (_____) _____

Email Address: _____

Best way to contact: Home phone Cell phone Other _____

I am a: Patient Parent of a patient Caregiver/family member of a patient

Tell us more about yourself:

Why do you want to be involved in the Patient Family Advisory Council?

Please share some examples of organizations or committees you have participated in (such as work, community or church):

Is there anything else you would like us to know?

Please choose the location that would be most convenient for you to attend 3-4 meetings per year:
 Farmington Manchester Litchfield Waterford

Is there another location that you would prefer we consider?

Thank you for taking the time to complete this application! Please return this completed form to:
Nikki Markie, Patient Experience Specialist
3 Farm Glen Blvd, Farmington, CT 06032
Phone: 860-674-7325
Email: nmarkie@prohealthmd.com