Application: Patient & Family Advisory Council (PFAC)

Name: _____ Today's date: _____
(Please print)

Home Address: _____
(Please print; include street address, town, state and 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 PFAC?

_____

_____

List any organizations or committees you have been a part of (work, community and/or church):

_____

_____

_____

Is there anything else you'd like us to know?

_____

_____

Thank you for taking the time to complete this application.
Please send it to:

Patient Experience Department:
3 Farm Glen Blvd.
Farmington, CT 06032
Phone: 1-860-674-7325
Email: Feedback@prohealthmd.com

Join Our Patient & Family Advisory Council!

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