Patient and Family Advisory Council
Membership Application
War Memorial Hospital

Contact Information:

Name: _____ Address: _____

_____

Phone:_____ Best Method of Contact: _____

Email: _____ Best time/day to Contact: _____

Experience Information:

I am a: _____ Patient _____ Family Member

What area(s) of the hospital did you or your family experience?

Tell us about the experience(s). What could have been improved? What impressed you?

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

Is there anything else you would like us to know?

Thank you for taking the time to complete this application! Please return this completed form to :

War Memorial Hospital
Quality Management Department
500 Osborn Blvd
Sault Ste. Marie, MI 49783

You will be contacted within the next 30 days regarding the status of your application.

_____ _____

Signature *Date*