St. Bernard Hospital and Health Care Center

Patient Family Advisory Council for Quality and Safety

Please tell us about yourself and your experience or interest in engaging patients and family members to improve the care we offer at St Bernard Hospital. The information you share is kept private.

Your Name: _____

Address: _____

City_____State_____Zip code_____

Email: _____

Home Phone: _____ Mobile/Cell: _____

Please tell us about your racial and ethnic background. This will help us ensure diversity in the membership of the Patient Family Advisory Council for Quality and Safety.

1) What is your ethnic background?
   a. ___ Hispanic, Latino, or Spanish
   b. ___ Not of Hispanic, Latino, or Spanish origin
   c. ___ Do not want to say

2) What is your race? (One or more can be checked)
   a. ___ American Indian/Alaska Native
   b. ___ Asian
   c. ___ Black or African American
   d. ___ Native Hawaiian/Other Pacific Islander
   e. ___ White
   f. ___ Some other race
   g. ___ Do not know
   h. ___ Do not want to say

3) What is your age range?
   a. ___ 18-30
   b. ___ 31-40
   c. ___ 41-50
   d. ___ 51-60
   e. ___ 61+

4) Do you work or volunteer in your community?
   a. ☐ Yes ☐ No

5) If you work or volunteer in your community, where do you work or volunteer?

_____

_____

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6) Why are you interested in volunteering your time to work with the Council to improve care at St. Bernard Hospital?

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7) What do you think patients and families will bring to Council efforts to offer excellent care and service?

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8) What services have you or your family received at St. Bernard Hospital?

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9) What more could we do as the community to deliver better service to patients and families who come to us for health care? Are their particular patient groups or types of patients that you are particularly concerned about?

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10) Are there any particular issues or priorities that you think the Council should work on?

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11) Do you like working in groups, speaking up and sharing your ideas?

☐ Yes ☐ No

12) Is English the language you mostly use?

❑ Yes ❑ No

13) If English is not the language you mostly use, what is the language you mostly use?

_____

14) Can you participate in meetings at St. Bernard Hospital or virally on weekday evenings?

❑ Yes ❑ No

15) Are you willing to sign an agreement promising to keep information about St. Bernard Hospital's patients private?

❑ Yes ❑ No

By signing this application, I request consideration to be a member of the Patient Family Advisory Council for Quality and Safety at St. Bernard Hospital. I understand that I may have access to confidential patient information and confidential quality and safety information. I understand that I must keep all such information confidential and that I will not share this information in any way with anyone. I understand that I will be provided specific training on policies, procedures and confidentiality.

_____ **Date**: _____

Signature of Applicant

Thank you for applying to be on the Patient Family Advisory Council for Quality and Safety.

If you have questions about the Council, call (773) 962-4165.

Please email your application to: dsinclair@stbh.org

You can mail or deliver your application to:

Diahann Sinclair
V.P., Organizational and
Community Development
St. Bernard Hospital
326 West 64th Street
Chicago, IL 60621
Attn: Advisory Council