

PATIENT & FAMILY ADVISOR APPLICATION

Thank you for your interest in becoming a Patient and Family Advisor at Inova. Please complete the information below and return your completed form to: chastity.johnson@inova.org.

PERSONAL INFORMATION

Name: _____

First

Middle Initial

Last

Nickname

Address: _____

City: _____ State: _____ ZIP: _____ DOB (mm/dd/year): _____

Home Phone: _____ Work Phone: _____ Ext.: _____

E-mail Address: _____ Cell/Pager: _____

BACKGROUND

We seek a diverse representation of our patient experiences and ask that you voluntarily self-identify with any of the following: (You do not have to answer these if it makes you uncomfortable.)

Gender (male or female): _____ Age: _____ Race: _____

Ethnicity: _____ Religion: _____

Language(s) spoken: _____

Assistive Needs, if applicable (i.e., Deaf, Blind, etc.): _____

Choose one of the following:

 I am a patient/former patient I am a family member of a patient/former patient Other: _____

At which Inova facility was your care/your family member's care provided: _____

Date(s) of your care experience: _____

