

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 us at: yourexperience@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 (ie, 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: _____

Level of Participation Interest:

 Monthly Patient & Family Advisory Council Meetings Staff Meetings Lunch & Learn Sessions with Staff

Staff Training
 Patient/Family Representation on Facility Committees (Please specify area of interest: _____)
 Other: _____

All Inova facilities are tobacco-free environments. Will you be able to comply with this policy? Yes No

DISCLAIMER: For security purposes, we conduct a background check on all adult volunteers. Conviction for a crime will not necessarily bar you from our program. We also consider your age at the time of the offense. Please answer the following:

Have you ever been convicted of a crime other than a minor traffic violation or ordered by a court to perform community service?

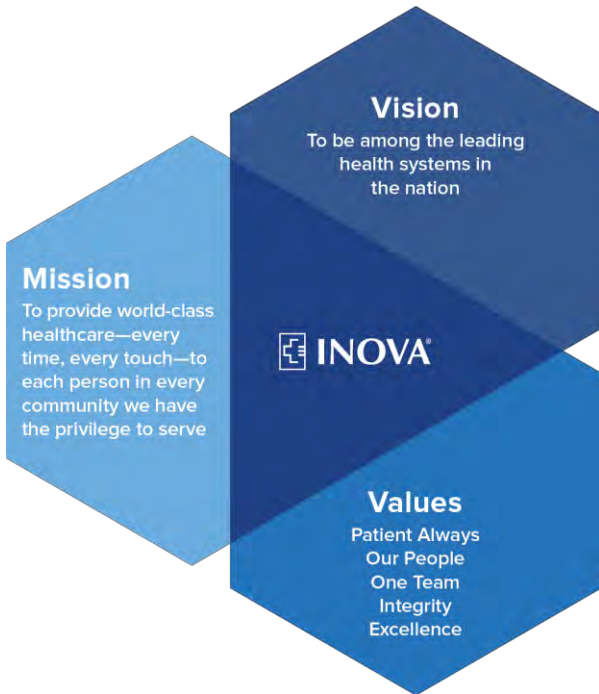
Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____
First Last

Home Phone#: _____ Work Phone #: _____ Cell #: _____

INOVA MISSION. VISION & VALUES



The graphic consists of three overlapping blue hexagons. The top hexagon is dark blue and contains the word "Vision" and the text "To be among the leading health systems in the nation". The bottom hexagon is medium blue and contains the word "Values" and the list "Patient Always, Our People, One Team, Integrity, Excellence". The left hexagon is light blue and contains the word "Mission" and the text "To provide world-class healthcare—every time, every touch—to each person in every community we have the privilege to serve". The Inova logo is centered in the overlapping area of the top and bottom hexagons.

Inova is a global leader in personalized health, which leverages precision medicine to predict, prevent and treat disease, enabling individuals to live longer, healthier lives. At Inova, we serve more than two million people each year from throughout the Washington, DC metro area and beyond.

We are shaping the future of health through our integrated network of hospitals, primary and specialty care practices, emergency and urgent care centers, outpatient services and destination institutes. Our commitment to health and wellness is further reflected in our sustainable practices. Inova is home to world-class researchers, expert medical specialists and renowned scientists, who are driving innovation to improve patient care, prevent disease and promote wellness.

SIGNATURE

I confirm that the above information is truthful and provided freely.

Signature: _____

Date: _____