



## Patient/Family Advisor Sign-up Form

Would you be a partner with us to deliver excellent medicine and compassionate care every time in every encounter? To reach this goal, we need your ideas, feedback and participation as together we improve the experience of care for our patients and families. We are seeking individuals for a variety of opportunities – both short term and ongoing.

**Yes, I would like to volunteer by sharing my experiences, time and ideas. Please contact me so my voice/experience can make a positive difference.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
City Zip

County you live in: \_\_\_\_\_ May we contact you? Yes

Clinic locations where you receive services? [Check all that apply]

- Main Clinic on Willamette
- Barger Medical Building
- Santa Clara Clinic
- Junction City
- South Eugene Clinic
- RiverBend Pavilion
- Hilyard Street Clinic (across from SHMC)
- Other: \_\_\_\_\_

I (or my family) receive services from:  Pediatrics  Adult/Family Medicine  
 Specialty Dept. \_\_\_\_\_  Behavioral Health  Other \_\_\_\_\_

Do you have Internet access from home?  Yes  No

Email address: \_\_\_\_\_ May we contact you?  Yes

I am a patient with a chronic health condition (e.g. diabetes, congestive heart failure, asthma, depression, arthritis).

I am involved in the care of someone who has a chronic health condition.

I am a patient/family member receiving preventative and/or occasional illness care

I was referred by: \_\_\_\_\_

**Please indicate the ways in which you would like to participate as a Patient/Family Advisor:**

\_\_\_ Phone Interview: Share your opinion and respond to survey questions over the telephone.

\_\_\_ Focus Group: Provide feedback in a group format with other patients/family members.

\_\_\_ Participate on Committees: Bring the patient/family perspective to committee meetings.

\_\_\_ Story Sharing: Share your health care experiences with care providers and other patients.

\_\_\_ Be a partner in making improvements to specific physician and specialist services

X Be a member of a Patient Advisory Council

Please return this form to: **Sheila Miller, Administration**  
**3377 RiverBend Drive**  
**Springfield, OR 97477**  
**(541) 222-6242**