

## PROVIDENCE MEDICAL GROUP Patient & Family Advisor Application

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

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

What is the best way to contact you? (circle one) **Home** **Work** **Cell** **Email**

Please check all that apply below:

- I am a patient at a Providence Medical Group (PMG) clinic  
     →If yes, from which PMG clinic location(s) do you receive services? \_\_\_\_\_
- I am the family member of a patient at a PMG clinic: \_\_\_\_\_
- I am a patient with a chronic health condition (e.g., diabetes, 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

**SKILLS & INTERESTS** If you wish to provide more information, please use the space below to describe any special training, interests, hobbies or experiences you feel could be valuable to your work as a Patient & Family Advisor with Providence Medical Group

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Please put an 'X' in the Day(s) and Time(s) you are available to meet for an interview:

	Monday	Tuesday	Wednesday	Thursday	Friday
Mornings					
Afternoons					
Evenings					

If you have questions please call, Angela Mitchell, 503-893-6613 or email [angela.mitchell@providence.org](mailto:angela.mitchell@providence.org)

**Please return your completed application to: Providence Medical Group – Education  
 Attention: Angela Mitchell  
 PO BOX 4488  
 Portland, OR 97208-9937**