



Patient and Family Advisor Application Form

Name (First and Last): _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Email Address: _____

Preferred contact (circle one): Phone Email

The following questions will help us get to know you better.

1. Are you a...

- ☐ Patient
- ☐ Family member of a patient

2. When was your care experience at this hospital? (Check all that apply)

- ☐ 2024 to current year
- ☐ 2023
- ☐ 2022
- ☐ 2021
- ☐ 2020 or before

3. What language(s) do you speak? _____

4. Which services have you or your family member(s) used at *Castleview Hospital*? (Check all that apply)

- ☐ ER/ICU Department ☐ Lab/Radiology Department ☐ Med/Surg Department
- ☐ Outpatient Surgery ☐ Physician Services ☐ Women's Services

5. We recognize that our patients and family advisors have busy lives. How much time are you able to commit to being a patient and family advisor? (Check one)

- ☐ Less than 1 hour per month ☐ 3 to 4 hours a month
- ☐ 1 to 2 hours per month ☐ More than 4 hours per month



6. Are you available to serve as an advisor for at least 1 to 2 years?

☐ Yes

☐ No

Please tell us about yourself.

7. Why do you want to become a patient and family advisor?

8. Please briefly describe any experience you may have as a board or committee member.

9. What *Castleview Hospital* services or projects are you passionate about or interested in working to improve?

10. Please share anything about yourself that you think would add to the benefit of our team of advisors.

Thank you for taking the time to complete this application!

Please return this form to **Amy Jones, Castleview Hospital Social Worker – 300 North Hospital Drive, Price, UT 84501** or amy.jones1@lpnt.net by June 30th, 2025.

Before becoming an active PFAC member you will be asked to sign a confidentiality agreement, agree to a routine background check, participate in our interview process and attend both volunteer and PFAC orientation.

Signature: _____ Date: _____