



# PATIENT AND FAMILY PARTNERSHIP COUNCIL APPLICATION

## Applicant Information:

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street Address Apt/Unit #

\_\_\_\_\_ City State Zip Code

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Social Media Tags (If any): \_\_\_\_\_

## Tell Us About Yourself

1. Please tell us a little about yourself, your interests, background. What do you want us to know?
2. Why are you interested in joining the Copper Queen Community Hospital's Patient and Family Partnership Council?
3. Do you have any special skills, training or hobbies that you feel will be useful to the Patient and Family Partnership Council?
4. Have you received care at Copper Queen Community Hospital within the past two years { } Yes { } No  
If yes, where was care received: \_\_\_\_\_  
If yes, how many times have you received care at Copper Queen Community Hospital during the past 2 years?  
\_\_\_\_\_
5. Has a loved one received care at Copper Queen Community Hospital during the past two years? { } Yes { } No  
If yes, where was care received: \_\_\_\_\_





## Permissions

I give Copper Queen Community Hospital permission to share my name, community, organization, and photo on their website: { } Yes { } No

I give Copper Queen Community Hospital permission to tag me in social media posts and website content about activities related to the Council. { } Yes { } No

Have you attached a photo? (Optional) { } Yes { } No

## Copper Queen Community Hospital Volunteer Agreement

If accepted onto the Copper Queen Community Hospital Patient and Family Partnership Council, I agree:

1. To donate my time and services to the organization without contemplation of compensation or future employment.
2. To hold as absolutely confidential all information that I may obtain directly or indirectly concerning patient and staff and not seek to obtain confidential information from a patient. I will also maintain confidentiality of organizational sensitive information; this includes but is not limited to information, data, reports, analyses, processes, know-how, research, practices, and strategies.
3. Be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others and strive to make my volunteering professional in quality.
4. Carry out assignments and seek assistance when necessary.
5. I understand that the Patient and Family Partnership Council reserves the right to terminate my volunteer status as a result of any circumstances which, in the judgment of the Administrative Director, would make my continued service as a patient advisor volunteer contrary to the best interests of the organization.

## Signature

Signature:

## Questions?

For questions about the Patient and Family Partnership Council, please contact Janet Emro at [jemro@cqch.org](mailto:jemro@cqch.org) and/or 520-432-6526.

Please return completed application to Janet Emro at Copper Queen Community Hospital 101 Cole Ave., Bisbee, AZ 85603 c/o Med-Surg Dept. or by email to [jemro@cqch.org](mailto:jemro@cqch.org).