BRIDGEPORT HOSPITAL
YALE NEW HAVEN HEALTH

Patient and Family Advisory Council Membership Application

Name:_____

Mailing Address:_____

City:_____ State:_____Zip:_____

Home Telephone:_____Work Telephone:_____

Cell:_____ E-mail address:_____

1. Have you or a family member received care at Bridgeport Hospital within the past year? Y/N
   Area(s) where care was received (please check all that are applicable):

   ☐ Inpatient ☐ Emergency Department ☐ Outpatient
   ☐ Fairfield Urgent Care ☐ Huntington Walk-in ☐ Surgease
   ☐ Outpatient infusion ☐ Medease

2. Why would you like to be a member of the Patient and Family Advisory Council?

   _____
   _____
   _____

3. What area(s) of concern do you have that you would like to see the Patient and Family Advisory Council address?

   _____
   _____
   _____

4. What special interests or experiences would you like to offer the Council?

   _____
   _____
   _____

5. We believe the Patient and Family Advisory Council should reflect the diversity of the patient population that Bridgeport Hospital serves. In light of this, please share anything about yourself that you think would add to the diversity of the Council.

   _____
   _____
   _____