



ProHealth Care Medical Associates (PHCMA)
**PATIENT ADVISORY
COUNCIL APPLICATION**

Today's Date: _____

Contact Information (please print):

Name: _____

Home Address: _____

City/State/Zip: _____

County: _____

Daytime Phone: _____ Best day/time to call: _____

Evening Phone: _____ Best day/time to call: _____

Email Address: _____

1. What is your preferred way of receiving communication about the Council?
 Email **Telephone**
2. Is it okay to share your contact information (address, telephone number and email address) with other members of the Council?
 Yes **No**
3. Have you received care at ProHealth Care Medical Associates within the last 12 months?
 Yes **No**
If Yes, at which clinic did you receive care? _____
4. Overall, how would you rate your experience at ProHealth Care Medical Associates?
 Very Good **Good** **Fair** **Poor** **Very Poor**
5. Have you ever received care at Waukesha Memorial Hospital or Oconomowoc Memorial Hospital?
 Yes **No**



PROHEALTH CARE
MEDICAL ASSOCIATES

6. **This section is optional.**
 The questions are designed to help us make our committees as diverse as possible:

a. Ethnicity: **Hispanic/Latino** **Non-Hispanic/Latino**

b. Race: **White** **Asian** **South Asian** **Black**
 American Indian/Alaskan **Other**

c. **Primary Language Spoken:** _____

d. Gender: **Male** **Female**

e. Age category: **18-24** **25-35** **36-45** **46-55** **56-65** **Over 65**

f. Do you have children under the age of 18 living in your household? **Yes** **No**

8. References (if any):
 If you were referred by a ProHealth Care employee, please include their name below. If you would like to provide additional references please attach to application.

Name: _____ **Department:** _____

9. I give permission to the PHCMA Patient Advisory Council (or their designee) to discuss my application with the above reference.

Name (Signature): _____ **Date:** _____

10. Tell us more about yourself and your experiences:

- a) Why would you like to be involved on the Patient Advisory Council?

- b) We believe the Patient Advisory Council should reflect the diversity of the communities we serve. Please share anything about yourself or family that you think would add to the diversity of this program. You might consider your diversity to be: ethnic, racial, age, spiritual, social, economic, educational, geographic, gender, sexual orientation, unique family structure, disability-related, chronic illness, single parent, full-time parent, grandparent, etc.

c) Is there anything else you would like us to know?

I understand that completion of this application does not bind the applicant or the program coordinators in any way. The Council reserves the right to choose participants that best meet the needs of the program. Before participating in PHCMA's Family Advisory Council, you will be asked to sign a confidentiality agreement.

Name (Signature): _____ **Date:** _____

Thank you for your interest!

Please mail or fax your application to:
 Cyndi Fritz, Service Excellence Specialist
 ProHealth Care Medical Associates
 N17 W24100 Riverwood Drive, Suite 250
 Waukesha, WI 53188
 Fax: 262-928-5835

Please contact Cyndi with any questions either by phone at 262-928-4871, or email cynthia.fritz@phci.org