

Family Advisory Council

Eligibility Requirements

NAME

EVENING PHONE

ADDRESS

E-MAIL

CITY / STATE / ZIP CODE

EDUCATION

DAYTIME PHONE

OCCUPATION

PRIMARY LANGUAGE SPOKEN

ANY ADDITIONAL SPOKEN LANGUAGES

Has your child been a patient at *Florida Hospital for Children* in the last two years?

- Yes
 No

Please check any of the units of services you have used in the last two years:

- | | | |
|--|---|--|
| <input type="checkbox"/> Children's Emergency Center | <input type="checkbox"/> Outpatient Surgery | <input type="checkbox"/> PPCU |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Neonate ICU | <input type="checkbox"/> Radiology/X-Ray |
| <input type="checkbox"/> General Pediatric Unit | <input type="checkbox"/> PICU | <input type="checkbox"/> Special Care Nursery level 11 |



Florida Hospital
for Children



Please briefly describe your child's medical story.

We believe the Family Advisory Council should reflect the diversity of patients, families and friends who use our hospital. Please share anything that you think would add to the diversity of our committee. (You might consider diversity to include ethnicity, race, spiritual beliefs, economics, gender, or disability related.)

Council members on the Family Advisory Council will work together with hospital staff . Please explain why you think parents and staff working together on different projects is beneficial.

Why do you want to be a member of the Family Advisory Council?

Do you have any ideas for improvement?

Thank you for completing this application for the Family Advisory Council. If you have any questions please contact Traci Woods at 407-303-5585 or by e-mail at Traci.Woods@flhosp.org. You may fax the application to 407-303-7708. Council members are considered volunteers of the hospital and are subject to a background check by the hospital.

