

Patient and Family Advisory Councils (PFACs) Membership Application

Please indicate to which Council you are applying:

- Dana-Farber/Brigham and Women's Cancer Center's **Adult Patient and Family Advisory Council (APFAC)**
 Dana-Farber/Children's Hospital Boston Cancer Care's **Pediatric Patient and Family Advisory Council (PPFAC)**

Thank you for your interest in the Patient and Family Advisory Councils. Membership on either Council requires your successful completion of the registration process with the DFCI's Volunteer Services Department, including but not limited to: a health screening which includes TB testing, a criminal background check, a formal interview process, as well as a mandatory volunteer orientation. All of your information will be treated as confidential. Membership on either Council requires attendance at monthly Council meetings and participation on at least one committee of your choice.

Please PRINT all information clearly:

Name: _____

Address: _____ City/State/Zip Code: _____

Telephone number(s): Please indicate preferred phone number and best time to reach you: _____

Work _____ - _____ - _____ Home _____ - _____ - _____ Cell _____ - _____ - _____ Fax _____ - _____ - _____

E-mail address: _____

Please indicate if you are:

For Adult Council: Adult patient currently in treatment Family member of adult patient currently in treatment
 Adult cancer survivor Family member of adult cancer survivor
 Bereaved family member

For Pediatric Council: Adolescent/teen patient currently in treatment Family member of pediatric/adolescent/teen patient currently in treatment
 Adolescent/teen cancer survivor Family member of pediatric/adolescent/teen cancer survivor
 Bereaved parent or family member

Diagnosis [Type of cancer] _____ Age at diagnosis: _____

Year of original diagnosis: _____ Year treatment completed (if applicable): _____

What did your/your family member's care involve? [Check all that apply]

Surgery Radiation Therapy Integrated [Complementary/Alternative] Therapy Chemotherapy

If family member, what is relationship to patient? _____

If the patient is a pediatric patient, is the applicant the legal guardian? _____

Why would you like to become a member of the Council? _____

Received by PFACs Office: _____

Please list your area(s) of special interest: _____

Comments related to treatment experience(s): _____

Conditions of Volunteer Services (Please read before signing):

Prior Convictions (Please read this carefully before answering)

Please answer the following question below. Please know that you may answer “NO” to the question below if you have a criminal record which is: (a) A sealed record on file with the commissioner of Probation, (b) You were determined to be delinquent or to be a child in need of services, which did not result in a complaint transferred to Superior Court for criminal prosecution, or (c) Your crimes were misdemeanors and they occurred five or more years ago. **Note: A conviction record will not necessarily be a bar to volunteer service.**

Have you been convicted of a felony or misdemeanor? Yes No
[If yes, attach details including date, location (city), nature and offense and disposition.]

I certify that the statements made in this application are true and correct and have been given voluntarily. I understand that I will not be paid for my services as a volunteer member of the Patient and Family Advisory Council. I agree to abide by the guidelines of Volunteer Services, to respect patient confidentiality, and to uphold the traditions and standards of Dana-Farber Cancer Institute. I understand that membership on the Adult or Pediatric Patient and Family Advisory Council will be based upon approval from Volunteer Services, Occupational Health Services, Council Co-Chairs and Program Manager. Professional staff will choose volunteers they feel are best suited for the Advisory Councils based on interviews and group consensus. Volunteers will demonstrate a readiness to help others, maintain respect for collaboration and assist DFCI in delivering quality patient cancer care. By signing this application, I am authorizing the staff of the Advisory Council to discuss my participation in the program with my clinical care staff, including physician, nurse or social worker/psychosocial provider.

I understand that membership on the Council requires my commitment to attend monthly Council meetings and to participate on at least one committee of my choice.

Applicant’s Signature _____ Date _____

For those applying as a family member: To assure compliance with Federal HIPAA regulations, family members must include patient’s name and obtain his/her signature to indicate that s/he understands you may use his/her name and/or medical history in your capacity as Council member.

Patient Name: _____ and Signature: _____ Date: _____

Please return completed application to: Patient and Family Advisory Council Office, Dana-Farber Cancer Institute, SW-G160, 44 Binney Street, Boston, MA 02115. You may contact the PFACs’ office via telephone at (617) 632-4319 or via e-mail at pfac@dfci.harvard.edu.