Thank you for your interest in joining the Pediatric Patient and Family Advisory Council (PPFAC). The PPFAC is dedicated to assuring the delivery of the highest standards of comprehensive and compassionate health care provided by Dana-Farber/Children’s Hospital Cancer Center. Working in active partnership throughout the Institute, the Council strengthens communication and collaboration among patients, families, caregivers and staff; promotes patient and family advocacy and involvement; and proposes and participates in the development and evaluation of oncology programs, services, and policies.

Eligibility
A teen (18 years of age or older)/young adult patient or family member of a person treated at Dana-Farber/Children’s Hospital Cancer Center, you are eligible to apply for Pediatric PFAC membership.

Membership requires a three-year commitment (renewable once for an additional three years). Members are expected to participate in all monthly regular meetings and to participate on a minimum of one committee and/or project.

Members must be able to commit to attending monthly Council meetings (usually the 4th Tuesday of the month from 5:30-7:30pm) and participating on committees and projects (some of which require daytime hours)

Application Process
Prospective applicants are required to complete the attached membership application. New membership begins in January; however, the Council retains the right to fill vacancies on a rolling basis as needed. Please include the following information with the application:

• An interest statement including, but not limited to, the following information:
  o Why you are interested in Council membership
  o What patient advocacy means to you
  o Why you believe you will be an advocate for patient and family care
  o What qualities and skills you will contribute to the Council
  o Examples of your experience of group membership (if applicable)

Please return the completed application and required documents via US Postal Service, email or fax to: Patient and Family Advisory Councils Office, Dana-Farber Cancer Institute, YC-151, 450 Brookline Avenue, Boston, MA 02215, pfac@dfci.harvard.edu or fax # 617.582.7430. If you have any questions, you may contact the PFACs office via telephone at 617.632.4319 or via email.

Applications are reviewed upon receipt. Potential members are contacted for on-site interviews with staff and Council members. Accepted applicants must complete health screening requirements (including documentation of vaccine history and a TB test) and attend an on-site Volunteer and PFACs orientation. Orientation sessions occur twice annually – March and September.
Section One:

Name______________________________________________________________________________________________________________________
Address___________________________________________________________________________________________________________________
Telephone Please indicate preferred phone number and best time to reach you _________________ AM/PM
Work_______________________________      Home__________________________________      Cell___________________________________
Email address_____________________________________________________________________________________________________________

Are you eligible to work in the United States of America?   Yes _____      or         No______

Section Two:

Please check the appropriate line:

____ Adolescent/teen patient currently in treatment
____ Family member of pediatric/adolescent/teen patient currently in treatment
____ Adolescent/teen cancer survivor
____ Bereaved parent or family member
____ Family member of pediatric/adolescent or teen survivor
____ If family member, your relationship to patient

Section Three:

Patient Diagnosis (type of cancer)_________________           Patient age at diagnosis___________________________________
Year of original diagnosis___________________________          Year treatment was completed (if applicable) __________

What did your/your family member's care involve? Please check all that apply:

____ Chemotherapy    ____ Radiation Therapy    ____ Nutritional Counseling
____ Integrative Therapy(ies)    ____ Speech and Swallow Counseling    ____ Surgery
____ Spiritual Services    ____ Social Services    ____ Other (please specify)
____________________________________

Section Four:

Your area(s) of interest, please check all that apply:

____ Clinical Care    ____ Clinical Research & Trials    ____ Communication, Marketing & Public Relations
____ Council Operations    ____ Human Resources    ____ Inpatient Care
____ Improvement    ____ Supportive Resources & Services    ____ Patient Safety & Quality
Conditions of Volunteer Services  Please read before signing

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 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 Pediatric Patient and Family Advisory Council will be based upon approval from Volunteer Services, Occupational Health Services, Council members and the director of Volunteer Services and the Shapiro Center for Patients and Families. By signing this application, I am authorizing the staff of the PPFAC to discuss my participation in the program with my or my family member’s clinical care staff, including physician, nurses, social works or other psychological providers.

Volunteers will demonstrate a readiness to help others, will maintain respect for collaboration and will assist DFCI in delivering quality patient and family cancer care.

I understand that membership on the Council requires my commitment to attend monthly Council meetings and to participate on committees, task forces and/or special projects throughout my term. Membership terms are one year in length and may be renewed for a maximum of three terms.

Applicant Signature:_________________________________________ Date: ___________________________

For those applying as a family member: In order to assure compliance with the Federal HIPAA regulations, family members must include the patient’s name and obtain his/her signature to indicate that he/she understands you may use his/her name and/or medical history information in your capacity as Council members. If the patient is a minor and the family member is not the legal guardian, the applicant must obtain the signature of the minor’s legal guardian.

Patient name:__________________________________________________________

If applicable, patient signature:_________________________________________ Date: ___________________________

If applicable, legal guardian’s name (please print):______________________________________________

Legal guardian’s signature:_________________________________________ Date: ___________________________

Parental consent for participants:_________________________________________ Date: ___________________________