Dana-Farber Cancer Institute’s Adult Patient & Family Advisory Council

Thank you for your interest in joining the Adult Patient and Family Advisory Councils (APFAC). The APFAC is dedicated to assuring the delivery of the highest standards of comprehensive and compassionate health care provided by Dana-Farber Cancer Institute. Working in active partnership throughout Dana-Farber, 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.

If you are a patient, family member, or caregiver of a person treated at Dana-Farber, you are eligible to apply for Adult PFAC membership.

Membership requires a minimum of a one-year commitment (renewable for six years), attendance at monthly Council meetings and participation on a minimum of two committees, task forces or special projects.

**Application Process**

Prospective applicants are required

1. to complete the attached membership application
2. submit an interest statement including, but not limited to, the following information:
   - why you are interested in Council membership
   - what patient advocacy means to you
   - why you believe you will be an advocate for patient- and family-care
   - what qualities and skills you will contribute to the Council
   - the amount of time you are able to commit to Council work
   - examples of your experience of group membership (if applicable)

Please return the completed application and required documents via email to Renee Siegel, Program Manager, PFAC at Renee_Siegel@dphi.harvard.edu or US Postal Service: Renee Siegel, Dana-Farber Cancer Institute, Yawkey Center, YC-151, Boston, MA 02215 or fax # 617.582.7430. If you have any questions, you may contact Renee at (617) 632-4319 or via email.

Applications are reviewed upon receipt. Potential members are contacted for on-site interviews with staff and Council Co-Chairs. Accepted applicants must complete health screening requirements (including documentation of vaccine history and a TB test) and attend an on-site Volunteer and PFAC orientation.
Section One:

Name __________________________
Address __________________________

Telephone
Work __________________________ Home __________________________ Cell __________________________

Please indicate preferred phone number and best time to reach you

Email address __________________________

Are you eligible to work in the United States of America? Yes ____ or No ____

Section Two:

Please indicate to which Council you are applying:

___ Adult patient currently in treatment
___ Family member or caregiver of adult patient currently in treatment

___ Adult cancer survivor
___ Family member or caregiver of adult cancer survivor

___ Bereaved family member
___ If family member, relationship to patient: ________________

Section Three:

Patient Diagnosis (type of cancer or blood disorder) __________________________
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
___ Surgery
___ Integrative Therapies (massage, reiki, acupuncture)
___ Speech & Swallow Counseling
___ Spiritual Services
___ Immunotherapy
___ CAR T-Cell Therapy
___ Other (please specify)
___ Nutritional Counseling

Section Four:

Your area of interest, please check all that apply:

___ Outpatient Care
___ Clinical Research & Trials
___ Communication, Marketing & Public Relations

___ Inpatient Care
___ Patient Safety & Quality Improvement
___ Young Adult Programming

___ Supportive Resources & Services
___ Health Disparities and Equity
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 Adult 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 Advisory Council 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, maintain respect for collaboration and assist DFC 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 or caregiver: 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.

Patient name: __________________________________________

If applicable, patient signature/date: ________________________________