Patient and Family Advisory Council (PFAC)
Membership Application

Thank you for your interest in our Atrius Health Patient & Advisory Council (PFAC).

Steps to being considered include completion of the following membership application and a telephone conversation with a member of our PFAC team. All your information will be treated confidentially.

Note: We have a limited number of spots open on the PFAC, and if you do not hear from us, we will be sure to keep your application on file for when spots become available.

CONTACT INFORMATION (PLEASE PRINT CLEARLY):

Name: ____

Address: ____

Preferred phone number: Work:____________Home:______________Cell:_________________

Email address:____

Preferred Mode of Contact: ▪ Phone number ▪ email ▪ Both

Please indicate if you are willing to share your contact information with other PAC members in the event you join our PAC: ▪ Yes ▪ No

YOUR EXPERIENCE WITH OUR PRACTICE:

Length of time with our practice: ▪ Less than 1 year ▪ 1-2 years ▪ 3-5 years ▪ More than 5 years

Our departments you have experience with (check all that apply):

▪ Internal medicine ▪ Pediatrics ▪ OB/GYN ▪ Behavioral Health
▪ Specialty department(s) ▪ Testing (e.g., x-ray, other) ▪ Lab ▪ Pharmacy

YOUR INTEREST IN OUR PATIENT AND FAMILY ADVISORY COUNCIL:

Please tell us why you are interested in serving as a patient/family advisor:

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Based on your experience with our practice, what are some of the topics you would like addressed at one of our Patient & Family Advisory Council meetings?

____

____

over →

Please record any other volunteer or advisory experience you have had in the past 3 years. Previous experience is not a requirement to be part of our Patient Advisory Council.
Organization(s):____
Role(s):____ ______

YOUR AVAILBILITY:

Are you available to attend Patient Advisory Council meetings early evenings during the week (excluding Fridays) ▪ Yes ▪ No

Please record any days or times that you are typically not available for meetings?_______________

Do you have a personal computer, tablet or cell phone that would enable you to participate in Patient Advisory Councils remotely through Zoom or Teams? ▪ Yes ▪ No

ABOUT YOU (TO GUIDE THE REPRESENTATIVENESS OF OUR COUNCIL - OPTIONAL):

Primary language spoken: ▪ English ▪ Spanish ▪ Chinese ▪ Other:___________________

Age: ▪ 18 - 24 ▪ 25-34 ▪ 35-44 ▪ 45-54 ▪ 55-64 ▪ 65 or older

Race:____

Ethnicity:____

Sexual Orientation:____

Gender Identity:____

Employment status: ▪ Working full time ▪ Working part time ▪ Unemployed ▪ Retired

Do you currently or did you previously work for a medical practice or hospital? ▪ Yes ▪ No

Health insurance: ▪ Through an employer ▪ Medicaid/MassHealth ▪ Medicare ▪ Other ▪ None

Are there any accommodations you would like us to be aware of (e.g., closed captioned meetings, interpreter, other)? ▪ Yes (specify):____________________________________ ▪ No

WAYS TO SUBMIT YOUR COMPLETED APPLICATION:

-Mail application to: Atrius Health, c/o of PAC application
275 Grove Street, Suite 2-300
Newton, MA 02466

-Scan or take a picture of your completed application and email* to patient_relations@atriushealth.org
-Complete the application over the phone with the assistance of a Patient Relations representative by calling: 617-559-8440.

**Note, this email address is not encrypted.*