Patient and Family Advisory Board
Membership Application

Thank you for your interest in the Patient and Family Advisory Board. Membership requires your completion of this membership application. Membership is reviewed by a committee. A phone interview will be required. All of your information will be treated as confidential. Please PRINT all information clearly.

PLEASE FAX the completed application to 312.695.1399 attn: Jessica MacLean or submit via e-mail to Jessica.maclean@northwestern.edu.

MISSION STATEMENT:
The Robert H. Lurie Comprehensive Cancer Center of Northwestern University is committed to being a national leader in the battle to overcome cancer.

To this end, the Lurie Cancer Center is dedicated to:
* Scientific discovery
* Advancing medical knowledge
* Providing compassionate state-of-the-art cancer care
* Training the next generation of clinicians and scientists

The Patient & Family Advisory Council Program is based on the principles of Patient- and Family-Centered Care, which is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among patients, families and health care providers. It is founded on the understanding that the family plays a vital role in ensuring the health and well-being of patients of all ages. In Patient- and Family-Centered Care, patients and families define their “family” and determine how they will participate in care and decision-making.

The 4 principles of Patient- and Family-Centered Care:

✓ Dignity & Respect
Health care providers listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into care planning and decision-making.

✓ Information Sharing
Health care providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, accurate information in order to effectively participate in care and decision-making.

✓ Participation
Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
✓ **Collaboration**

Patients, families and providers collaborate in policy and program development, implementation and assessment; in health care facility design; and in professional education, as well as in the delivery of care.

Name: ____________________________________________

Address: __________________________________________

City/State/Zip Code: __________________________________

Please indicate preferred phone number:  □ Cell      □ Home       □ Work

Telephone number(s):

Work _____ - _____ - _______  Home _____ - _____ - _______  Cell _____ - _____ - _______

E-mail address: __________________________________________

Birthday: _____________________________________________________________________________

Please indicate if you are:

□ 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               □ Childhood Cancer Survivor

Patient or Family member’s Diagnosis [Type of cancer] __________________________________________

Age at diagnosis: _____________________

Year of original diagnosis: ________________

Year treatment completed (if applicable): ________________

Who is your Physician? ________________________________________________________________

What did your/your family member’s care include? [Check all that apply]

□ Chemotherapy/Other drug Therapy       □ Clinical Trial

□ Radiation Therapy                     □ Surgery

If family member, what is relationship to patient?
_____________________________________________________________________________________

Were you or your family treated at Northwestern (all or part of therapy)?
_____________________________________________________________________________________

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What is your occupation, or list any skills/ hobbies:
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Why would you like to become a member of the Board?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

What do you want to bring to the Board?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Describe a memorable experience in your cancer journey:
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

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 Board. I agree to abide by the guidelines to respect patient confidentiality, and to uphold the traditions and standards of Robert H. Lurie Comprehensive Cancer Center of Northwestern University. Volunteers will demonstrate a readiness to help others, maintain respect for collaboration and assist the Lurie Cancer Center 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.

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: ________________________________________________________________

Signature: ________________________________ Date: ______________