Stony Brook Children's

Family Advisory Council
Application

The following information will be used to help us make selections for the Family Advisory Council at Stony Brook Children's Hospital. If any of your responses require additional space, please add pages to this application. All information will be held in the strictest confidence and only used for the purposes of selecting members for the Family Advisory Council. If you have questions, please contact Joan Alpers, Child Life Director, at (631) 216- 3636.

Date:

Name: Daytime Phone:

Street Address: Evening Phone:

City/State/Zip: Mobile Phone:

Email Address: Relationship to Patient:

What is the best way to contact you? ☐ Home Phone ☐ Mobile Phone ☐ Email
☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime

Please list the names and birth dates of your children who have received care at Stony Brook Children's.

Name: Name:

Birthdate: Birthdate:

Primary Diagnosis: Primary Diagnosis:

Please describe your child's medical story.

What would you like to tell us about your hospital experience(s).

What would you have improved about the experience?

What impressed you about your experience?

Tell us more about yourself

Why do you want to be involved in the Family Advisory Council?

Council members on the Family Advisory Council collaborate with hospital staff on a regular basis. Please explain why you think parents and staff working together on different projects is beneficial?

Family Advisory Council members will be involved in hospital affairs that may include: policies, patient safety, bereavement services, resource development, etc. Is there a part of the hospital that you are most interested in? If so, please explain.

If you have participated in any organizations or committees, please share some examples: (These examples may be from work, community, church, etc.).

What strengths would you bring to a Family Advisory Council?

The commitment to volunteer on the Family Advisory Council is a two-year commitment, meeting for two hours in the evening, once a month, 10 months of the year. Additional time may include subcommittee meetings by phone or in hospital with other committee members. At this time, can you think of any other obligations or responsibilities that would interfere with this commitment?

Is there anything else you would like us to know?

Please have the attached reference form filled out by a member of your child's healthcare team at Stony Brook Children's Hospital or private physician's office. Also, please provide the contact information for us to send a request for reference from someone who knows you well and is not a family member.

Reference Name:

Daytime Phone:

Email Address:

Thank you for taking the time to complete this application.
Please return this completed form to:
Joan Alpers, Director of Child Life Services
Phone (631) 216 3636
Stony Brook Children's Hospital
11 North, Room 009
Stony Brook, NY 11794-7111
Email : joan.alpers@stonybrookmedicine.edu

Before participating in the FAC you will be asked to sign a confidentiality statement and go through both volunteer and FAC orientation.

Signature: Date: