

Patient and Family Advisory Council Application

Name:

Phone:

Address:

Email:

Occupation:

Share why you are interested in joining the Wentworth-Douglass Hospital Patient and Family Advisory Council and would be a good representative for other patients and families?

Within the past two years, where have you or your family members received care at WDH? Check all that apply:

Inpatient

Emergency Department

Outpatient procedural or testing

Cancer Center

Surgical Services

Rehabilitation Services (PT/OT/Speech)

Medical Practice / Wentworth Health Partners

Other

What else would you like us to know about you?

Are you available for a virtual meeting the 2nd Wednesday of each month from 4:00-5:00 p.m.?

Yes

No

Additional demographic information (optional):

Age range:

18-24

25-34

35-44

45-54

55-64

65+

Race or Ethnicity – check all that apply:

American Indian or Alaska Native American

Native Hawaiian or Other Pacific Islander

Asian

White

Black or African American

Other

Hispanic

Education Level:

High School/GED

Undergraduate Degree

Master/Post Grad

PhD

Please return completed application to:
PatientExperience@wdhospital.org