Westfields Hospital™
HealthPartners Family of Care

Patient and Family Advisory Council Application Form

Thank you for taking the time to complete this membership application for the Westfields Hospital Patient and Family Advisory Council.

Date: _____

Name: _____

Address: _____

Email: _____

Home Phone:_____ Work Phone:_____

What is the best way to contact you and when?

Have you or a family member received care at Westfields Hospital within the past 3 years?

Yes No

If yes, please check all that apply:

__Ambulatory Care/Wound Care
__Cancer Center
__Cardiopulmonary Services/Sleep Studies
__Emergency Department
__Imaging Department
__Laboratory
__Medical Surgical Inpatient
__Outpatient Surgery
__Physical Rehabilitation
__Surgical Services
__Specialty Clinic

Please tell us why you would be interested in being a member of our Patient and Family Advisory Council.

Briefly describe your experience, either as a patient or family member, when receiving care at Westfields Hospital.

What unique perspective do you feel you would bring to the Council?

All information on this form is considered confidential and is intended for use by Westfields Hospital and the Patient and Family Advisory Council only. You will be contacted after we review your application regarding our upcoming meeting.

Thank you for your interest in being part of this important group. Please return this application to:

Betsy Johnson
Westfields Hospital
535 Hospital Road
New Richmond, WI 54017