RUSH UNIVERSITY Children's Hospital

Rush University Children's Hospital
Family Advisory Council
Membership Application

Date: ______________________

Name (*Please Print*): ____

Home Address: ____

City: ____________________________________ State: ____________ Zip: ________________

Preferred Phone Number (1): (____) ______________________

Preferred Phone Number (2): (____) ______________________

Best Time to Call: ☐ Morning (8am – noon) ☐ Afternoon (noon – 4pm) ☐ Evening (after 5pm)

Email Address: ____

Preferred Method of Contact: ☐ Email ☐ Phone

Relationship to Child(ren) Listed Below: ____

Children: *Please include additional information about these or other children on a separate sheet of paper.*

Name: ___________________________________

Birth Date: _______________________________

Has s/he been a patient at Rush? __Y __N

Please estimate the number of times per year this child uses Rush Pediatric services (*Inpatient, Outpatient, Satellites*): _____________

Name: ___________________________________

Birth Date: _______________________________

Has s/he been a patient at Rush? __Y __N

Please estimate the number of times per year this child uses Rush Pediatric services (*Inpatient, Outpatient, Satellites*): _____________

Name: ___________________________________

Birth Date: _______________________________

Has s/he been a patient at Rush? __Y __N

Please estimate the number of times per year this child uses Rush Pediatric services (*Inpatient, Outpatient, Satellites*): _____________

Name: ___________________________________

Birth Date: _______________________________

Has s/he been a patient at Rush? __Y __N

Please estimate the number of times per year this child uses Rush Pediatric services (*Inpatient, Outpatient, Satellites*): _____________

The following questions are designed to help us make our committee as diverse as possible. Please check all that apply.

Which of the following services at Rush University Children's Hospital has your child/children used? (Please check all that apply):

Outpatient Clinics

☐ Pediatric Primary Care
(*select location)*
- ○ Westgate/Jackson Building
- ○ Professional Building, Suite 940

☐ Lifetime Medical Associates
☐ Pediatric Subspecialty Clinic
(*select specialties)*
- ○ Adolescent Medicine
- ○ Cardiology
- ○ Developmental Pediatrics
- ○ Endocrinology/Diabetes
- ○ Gastroenterology
- ○ Genetics
- ○ Hematology/Oncology
- ○ Infectious Disease
- ○ Nephrology/Dialysis
- ○ Neurology/Neurosurgery
- ○ Psychiatry
- ○ Pulmonology
- ○ Surgery
- ○ Urology
- ○ Other:

_____
- ○ Other:

_____

Ambulatory

☐ Emergency Room
☐ Outpatient Surgery
☐ Lab
☐ Radiology
☐ Dialysis
☐ Satellite Clinics
If satellite, which one?
_____
_____

Inpatient Units

☐ NICU
☐ PICU
☐ General Pediatrics
☐ Other:
_____

Ethnicity (optional)

☐ African-American
☐ American Indian/Alaskan
☐ Asian / Pacific Islander
☐ Caucasian
☐ Hispanic/Latino
☐ Other _____
_____

L anguage (optional)

A. Primary Language Spoken: _____

B. What other language(s) do you speak that may be beneficial (*Please check all that apply*):

☐ American Sign Language ☐ Arabic ☐ English

☐ Mandarin ☐ Polish ☐ Spanish

☐ Other (*Please specify*): _____

PLEASE TELL US MORE ABOUT YOURSELF AND YOUR EXPERIENCES

How did you learn about the Family Advisory Council?

☐ Rush's website
☐ Family or friends
☐ Hospital Staff
☐ Other _____

What aspects of your family's experience would benefit the Family Advisory Council and other families at Rush?

_____

_____

_____

_____

_____

_____

_____

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The Family Advisory Council's goal is to reflect the diversity of families who use pediatric hospital services. Please share anything about your family that you think would add to the diversity of this program. (*You might consider your diversity to be ethnic, racial, spiritual, social, economic, educational, geographic, gender identity, sexual orientation, unique family structure, disability-related, chronic illness, single parent, full-time parent, grandparent, etc.)*

Is there anything else you would like us to know? (optional)

RUSH UNIVERSITY
Children's Hospital

I understand that completion of this application does not bind the applicant or the program coordinators in any way. The FAC reserves the right to choose participants that best meet the needs of the program. Before participating in the FAC, you will be asked to sign a confidentiality agreement.

Signature _____ Date _____

Completed applications may be submitted via:

E-mail

peds@rush.edu

Mail

1653 W. Congress Pkwy
466 Pavilion
Chicago, IL 60612