# Medical Associates of the Hudson Valley

## ***APPLICATION FORM FOR PATIENT AND FAMILY ADVISORS***

*Please print:*

**Name:**_____
(Last) (First) (MI)

**Address:**_____

**City:**_____ **State:**_____ **Zip Code:)**_____

**Home Phone:** (10 digits)_____ **Cellular Phone:** (10 digits)_____

**Work Phone:** (10 digits)_____

**E-mail Address:**_____

**Language(s) You Speak:**_____

**I am:** (Fill-in all that apply)

- A patient
- A family member of a patient
- Other, please specify _____

**Please list times when you are able to attend meetings:** (Fill-in all that apply)

- Daytime:_____
- Evening:_____
- Weekend:_____

**I/We would be interested in helping improve:** (Fill-in all that apply)

- Patient and family satisfaction tools
- Patient education materials
- The office care experience
- Patient safety and prevention of medical errors
- Education of new employees and other staff about the experience of care and effective communication and support.
- The coordination of care and the transition to home and community care
- Accessibility of care
- Issues of special interest (please describe):