Staff Adviser
Cincinnati Children's Hospital Medical Center

STAFF APPLICATION FORM.

Your Name:_____ Position/Title:_____

Division/Department_____ Email:_____

Phone:_____ FTE Status____ Mail Location_____ Years at Cincinnati Children's_____

1. Why are you interested in partnering with families on the Family Advisory Council?

2. What are some of the specific things that health care professionals do/have done to help you and your family when you receive health care services. (You may include experiences outside Cincinnati Children's.)

3. What are some of the things you would like to see us do differently to better help patients and families?

Please submit application by **June 24th**, by e-mailing form to Beth.Moone@cchmc.org
Please note: *Attendance is critical for all meetings*, held monthly (except for July and August) and alternating between days and evenings.