Patient Advisory Board Application
Community Health and Wellness of Greater Torrington

Date: _____

Name (First,Last,Middle Initial): _____ DOB: _____

Address (Home): _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Availability:

_____
_____

Check box that best applies:
Best reached by: ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email

Best time to be reached: _____

I am a: ☐Patient ☐Family Member ☐Caregiver ☐Community Partner ☐Agency

Services used: ☐Medical ☐Dental ☐Behavioral Health

Tell us a little more about yourself! (Use a separate piece of paper if needed)

1. Why do you want to be involved in the Patient Advisory Board?

2. How did you hear about the Patient Advisory Board?

3. Have you ever been a part of a board or council? What was your role/duty?

4. Tell us about your experience with Community Health and Wellness. What would you do to improve your experience?

By signing this form I, _____, agree to all HIPAA laws and understand that this is a confidential committee and what is discussed is not to be shared or talked about outside the meeting.

_____ _____

Signature of Applicant *Date*