**Volunteer Application**

**Personal Information**

**Name: (First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: (\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the best way to contact you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth: (m/d/y) \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_**

**Work/Volunteer History:**

**Have you worked in any healthcare setting?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you volunteered in at any healthcare facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please answer the following:**

**Please select your relationship to the patient:  
 \_\_\_\_\_\_\_Patient  
 \_\_\_\_\_\_\_Spouse/partner/significant other  
 \_\_\_\_\_\_\_Parent  
 \_\_\_\_\_\_\_Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been pregnant (or a family member to someone who has been pregnant) in the past 1-5 years?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Tell us about yourself:**

**Why would you like to be a member of the TIPQC Patient and Family Advisory Council?**

**What past experience, interest, or skills do you have that you could bring to this role?**

**What would be of interest to you when serving on the council? (Check all that apply)**

**\_\_\_\_\_\_\_\_\_\_\_Participating in the development of new TIPQC projects  
 \_\_\_\_\_\_\_\_\_\_\_Developing/reviewing TIPQC project documents (ex: Toolkits)  
 \_\_\_\_\_\_\_\_\_\_\_Developing/reviewing patient and family educational materials  
 \_\_\_\_\_\_\_\_\_\_\_Developing/reviewing website for patient/family understanding  
 \_\_\_\_\_\_\_\_\_\_\_Serving as an e-advisor – responding by email to questionnaires and surveys seeking your opinion.**

**Commitment Terms:**

**The time commitment required is a quarterly, one-hour meeting via Zoom. However, additional time may be required depending on the specific project to which you are assigned. If selected, we will work with you individually to involve you in an area based on your availability and interest.**

**Volunteer Agreement:**

**As a member of the TIPQC Patient and Family Advisory Council, I agree:**

**I hereby certify that the answers on this application are true and correct and that any misrepresentations or omissions of facts, or misleading or false information on my part will be grounds for dismissal as a volunteer.**

**I understand this is a voluntary role and my time is given for humanitarian or charitable reasons.**

**Applicant’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**