ABBEVILLE AREA MEDICAL CENTER

Smaller. Smarter. Safer.

Patient & Family Advisory Council Application

Date: _____

Name: _____

Mailing Address: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ E-mail Address: _____

1. Would you like to be on Abbeville Area Medical Center's Patient and Family Advisory Council?

   ___ Yes ___ No

2. What is your preferred way of receiving communication about the council?

   ___ E-mail ___ Regular Mail

3. Is it okay to share your contact information (address, telephone number, and e-mail address) with other members of the council?

   ___ Yes ___ No

4. Have you received care at Abbeville Area Medical Center for which this council is being formed?

   ___ Yes ___ No

   4a. If yes, in what AAMC department have you received care?

   _____

5. Do you have any dietary needs we should be aware of (i.e., vegetarian)? ___ Yes ___ No

   If Yes, please elaborate _____

6. Do you have any special needs we should be aware of? ___ Yes ___ No

   If Yes, please elaborate. _____

7. Why would you like to be on the council? _____

   _____

   _____

8. What issues would you like to see the council address? _____

   _____

   _____

9. What special interests or experiences would you like to offer to the council? _____

_____

_____

10. What days and times are better for you to meet? _____

_____

Please return the completed application by either email to

aellenberg@abbevilleareamc.com
sroundtree@abbevilleareamc.com

or mail to

Abbeville Area Medical Center
PO Box 887 Abbeville, SC 29620
Attention: Ambre Ellenberg