EDINBURG REGIONAL MEDICAL CENTER
A South Texas Health System Facility

PATIENT/FAMILY ADVISORY COUNCIL APPLICATION

EDINBURG CHILDREN'S HOSPITAL
A South Texas Health System Facility

Name *(Please Print)*

Home Address:

City: State: Zip:

Home/Work Phone: Cell Phone:

Email Address:

Have you or a family member been a patient at ERMC/ECH? ☐ Yes ☐ No How many times?

Where were you/they treated? In-Patient ☐ Emergency Room ☐ Out-Patient ☐

Please describe you or your family member's most recent experience with Edinburg Regional Medical Center/Edinburg Children's Hospital:

Why would you like to be involved with the Patient/Family Advisory Program?

***Notice:**

I understand that completion of this application does not bind the applicant or the program co-chairs in any way. The PFAC reserves the right to choose participants who best meet the needs of the program.

Signature *Date*

Thank you for your time and interest. If you have any questions please feel free to contact Cat Domian at 956-388-6635

Please return completed application to:
ERMC Administration Attn: Nina Kavarthapu (956)-388-6617