Athol Hospital
Member of the Heywood Healthcare Family

Patient & Family Advisory Council Application

1. Contact Information: {please print}

Name:_____ Telephone:_____
Address:_____ Email:_____
City/Town/Zip:_____

Age Group: [ ]0-18 [ ]19-39 [ ]40-50 [ ]51-64 [ ]65-79 [ ]80+

Race: [ ] Caucasian [] Asian [ ] Black or African American [ ] Pacific Islander/Hawaiian Native
[ ] American Indian/Alaskan Native [ ]Other:_____

Hispanic/Latino Origin: [ ]yes [ ]no Other Languages Spoken:_____

2. Within the past two years have you used any of the following services at Heywood Hospital? {Check those that apply}
   [ ]Emergency Room [ ]Inpatient Care [ ]Outpatient Clinic [ ]Surgery
   [ ]Lab [ ]X-Ray [ ]Other:_____

3. Have you used other community-based services within the past two years?
   [ ]Specialty Clinics [ ]Hospice [ ]Home Health Care [ ]Other:_____

4. References: {If any}

   If you were referred by employee or PFAC council member, please include name below

   _____ _____
   Name Contact Information

   _____ _____
   Name Contact Information

5. I give permission to the Patient/Family Advisory Council [or their designee] to discuss my application.

   Name/Signature:_____ Date:_____

Submit application to: Barbara Nealon, Director of Social Service by mail or Fax: 978-630-5047 or email : Barbara.Nealon@heywood.org Est. 9.9.16