STANFORD
HOSPITAL & CLINICS
*Stanford University Medical Center*

Cystic Fibrosis Adult Center at Stanford University Hospital

# The CF Adult / Family Advisory Council

**Membership Application** *(please print)*

The CF Adult Patient/Family Advisory Council at Stanford seeks a diverse membership in order to best represent all of our backgrounds, experiences, needs and challenges.

Ethnicity (optional)

☐ Causasian ☐ African-American

☐ Hispanic ☐ Asian

☐ Other

Primary language spoken at home:

_____

Name _____

Address _____

_____

City _____ State _____ Zip _____

Email _____

Phone _____ Cell _____

May we leave a message on your answering machine?

☐ Yes ☐ No

May we contact you through email?

☐ Yes ☐ No

I am: ☐ Male ☐ Female

☐ CF Adult ☐ CF Family Member ☐ Parent ☐ Sibling ☐ Spouse/Partner ☐ Friend

☐ Other family member _____

Healthcare Professional *(please state title)* _____

If you are a CF adult, how old are you? _____

If you are a family member, how old is your family member with CF? _____

How old were you or your loved one when diagnosed? _____

Where did you or your loved one receive CF pediatric care? _____

What services have you used at Stanford? *(Please check all that apply)*

☐ ER ☐ Clinic ☐ In-patient ☐ GI ☐ Endocrine ☐ ENT

☐ OB/GYN ☐ Transplant ☐ Other _____

If you or a family member has CF, about how many times have you (or your family member) been hospitalized at Stanford?

☐ None ☐ 1 – 3 ☐ 4 – 10 ☐ 11 – 20 ☐ more

Have you experienced adult CF care elsewhere? ☐ Yes ☐ No

If yes, where? _____

Do you have a family member, partner, or significant other on the current Advisory Council? ☐ Yes ☐ No

*please turn over and continue*

Please let us know why you want to serve on the Advisory Council.
*(250 words max, attach another page if needed)*

Do you have comments regarding treatment experiences that you wish to share with the Council? What are they?
*(250 words max, attach another page if needed)*

Are you willing to be interviewed as a part of the application process? ☐ Yes ☐ No

As a CF patient, are you willing to have a sputum culture every three months and to follow the CF Center's infection control guidelines? ☐ Yes ☐ No

I understand that completion of this application does not bind me, the applicant, or the existing council in any way. The council reserves the right to choose participants that best meet the needs of the program. Before participating on the advisory council you will be asked to sign a confidentiality agreement.

Name *(signature)*: _____ Date: _____

Please send your completed application to:

**Stanford CF Adult Patient**
**and Family Advisory Council**
Colleen Dunn
770 Welch Road, Suite 350
Palo Alto, CA 94304