Application for Cancer Patient and Family Advisory Council (PFAC)

UC San Diego
MOORES CANCER CENTER

If you are a patient, family member or caregiver of a person treated at UC San Diego Moores Cancer Center (MCC), you are eligible to apply for Patient and Family Advisory Council (PFAC) membership.

Membership requires a three-year commitment, attendance at monthly PFAC meetings and participation on at least one committee, task force or special project.

Application Process

Prospective applicants are required to complete the attached membership application. Please include the following information with the application:

- An interest statement including, but not limited to, the following information:
  - Why are you interested in PFAC membership
  - What patient advocacy means to you
  - Why you believe you will be an advocate for MCC patient and caregiver care
  - What qualities and skills you will contribute to the PFAC
  - The amount of time you are able to commit to PFAC work
  - Examples of your experience of group membership (if applicable)

Please return the completed application and required documents via US Postal Service, email, or fax to: Patient and Family Advisory Council Office, Attn: Liliana Cardenas, UC San Diego, Moores Cancer Center, 3855 Health Sciences Drive #0658, La Jolla, CA 92093-0658, moorespfac@ucsd.edu or via fax at (858) 822-3449. If you have any questions, you may contact the PFAC's office via telephone at (858) 246-0223 or via email at moorespfac@ucsd.edu.

The PFAC Executive Committee will review the PFAC application for Community Membership and have discretion to approve/disapprove the application. The Membership Committee will then review the approved application, meet with the potential Community member, and make a recommendation to the full Council. New Community members shall be voted in by a majority vote from the Full Council. Each new Community member must sign HIPAA and confidentiality statements.

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Section One:

Name:_____

Address: _____

Telephone: *Please indicate preferred phone number and best time to reach you*

Work: Home: _____

_____

Cell: _____ Email:

_____

Section Two:

Please indicate:

_____Patient currently in treatment _____Caregiver of patient currently in treatment

_____Cancer survivor _____Caregiver of cancer survivor

_____Bereaved loved one _____If caregiver, relationship to patient: _____

Section Three:

Type of cancer:

- ☐ Bone Marrow Transplant
- ☐ Breast
- ☐ Central Nervous System
- ☐ Colon & Rectal
- ☐ Gastro-intestinal
- ☐ Genito-urinary (Prostate, Bladder, Kidney)
- ☐ Gynecologic
- ☐ Head & Neck
- ☐ Hematologic (Lymphoma, Leukemia)
- ☐ Lung
- ☐ Melanoma
- ☐ Other _____

Year of original diagnosis: _____

Year treatment was completed (if applicable): _____

Are you being treated presently for cancer at MCC **Yes** or **No** or another Medical Facility **Yes** or **No**

If yes to another Medical Facility, name:_____

What did your loved one's care involve? Please check all that apply:

_____Chemotherapy _____Radiation Therapy _____Surgery

_____Other (please specify):_____

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Conditions of PFAC Membership
Please read before signing

I certify that the statements made in this application are true and correct and have been given voluntarily. I understand that I will not be paid for my services as a Community Member of the PFAC. I agree to abide by the By-laws of the PFAC, to respect patient confidentiality, and to uphold the traditions and standards of UC San Diego, Moores Cancer Center. I understand that Community membership on the Council will be based upon approval from Moores Cancer Center Leadership and a majority of the PFAC Staff and Community membership. By signing this application, I am authorizing the PFAC Staff Leadership to discuss my participation on the PFAC with my loved ones and my clinical care staff, including physicians, nurses, social workers, or other psychological and spiritual providers.

PFAC members will demonstrate a readiness to help others, maintain respect for collaboration, and assist MCC in delivering quality patient and caregiver cancer care.

I understand that membership on the Council requires my commitment to attend monthly Council meetings and to participate on committees, task forces and/or special projects throughout my term. Membership terms are three years in length.

Applicant signature/date:

_____

For those applying as a loved one/caregiver: In order to insure compliance with Federal HIPAA regulations, loved ones must include the patient's name and obtain his/her signature to indicate that he/she understands you may use his/her name and/or medical history information in your capacity as PFAC Community members.

Patient name:

_____

If applicable, patient signature/date:

_____