Application for ICN Family Advisory Council Member

Welcome! Thank you for your interest in joining the UCSF Benioff Children's Hospital Intensive Care Nursery Family Advisory Council (FAC). We believe the family perspective is essential to providing quality care for infants and their families and our family advisory council plays an important role in patient satisfaction efforts, improving how we provide care, and research opportunities.

Please email your completed application to Diana Rogosa, ICN Parent Liaison, at diana.rogosa@ucsf.edu

Your Name: _____

Home Address: _____

City: _____

Phone Number: _____ Best day/time to call: _____

E-mail Address: _____

PLEASE SELECT THE MEMBER-TYPE THAT INTERESTS YOU MOST*:*

We know that families have busy lives and we appreciate the time and energy that it takes to volunteer for the FAC role. In an effort to be mindful of your time, we offer two types of FAC members.

☐ ICN FAC full member [*approximately three hours per month*]

Attend at least six out of the nine FAC meetings per year (typically meetings are not held in the summer months or in December) and contribute online as needed between meetings to meet FAC goals and deadlines. May hold office and/or leadership position on the ICN FAC. May provide education on parent panels and/or support at Parent Support activities in the ICN. May also hold membership on UCSF Benioff Children's Hospital FAC or other committees.

☐ ICN FAC digital consultant [*as little as one hour per month*]

Provide input on FAC action items online (via email and/or ICN digital platform). Attend at least one meeting per year, over Zoom or in person. May also choose to provide education on parent panels, support at ICN Parent Support activities, or group subcommittees.

THE ICN FAC CONSULTS ON MANY ASPECTS OF THE ICN EXPERIENCE. PLEASE SELECT ANY AREAS OF SPECIFIC INTEREST TO YOU*:*

☐ Research opportunities

☐ Improving patient care

☐ Improving the family experience

☐ Peer support to ICN Families

☐ Education to staff and providers

☐ Preterm Birth Initiative, Family Integrated Care, or other specific projects.

Why are you interested in becoming a member of the ICN Family Advisory Council?

Please provide an example of a positive experience you had at UCSF Benioff Children's Hospital, San Francisco and/or one that could have gone better.

We believe the ICN Family Advisory Council should reflect the diversity of the families we serve. Please share anything about yourself or your family that you think would add to the diversity of this program. You might consider your diversity to be: ethnic, racial, spiritual, social, economic, educational, geographical, gender, sexual orientation, unique family structure, disability related, chronic illness, single parent, full time parent, grandparent, etc.

Is there anything else you would like us to know?

REFERENCE

Please include the name of a UCSF Benioff Children's Hospital staff member with whom you have worked (doctor, nurse, social worker, child life specialist, parent liaison, case manager, housekeeper, physical therapist, etc.)

Name: _____

Department: _____

UCSF Benioff Children's Hospital San Francisco

Family Advisory Council

PLEASE HELP US GET TO KNOW YOUR EXPERIENCE WITH YOUR CHILDREN AT UCSF BENIOFF CHILDREN'S HOSPITAL, SAN FRANCISCO (UCSF BCH-SF).

Child 1 Name: _____ Birth Date: _____

Does your child have special needs? ☐ Yes ☐ No
Were they a patient in the ICN at UCSF BCH-SF? ☐ Yes ☐ No
Have they been a patient in another unit at UCSF BCH-SF? ☐ Yes ☐ No

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Child 2 Name: _____ Birth Date: _____

Does your child have special needs? ☐ Yes ☐ No
Were they a patient in the ICN at UCSF BCH-SF? ☐ Yes ☐ No
Have they been a patient in another unit at UCSF BCH-SF? ☐ Yes ☐ No

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Child 3 Name: _____ Birth Date: _____

Does your child have special needs? ☐ Yes ☐ No
Were they a patient in the ICN at UCSF BCH-SF? ☐ Yes ☐ No
Have they been a patient in another unit at UCSF BCH-SF? ☐ Yes ☐ No

Please add an additional page if you have more children you'd like to tell us about.

Within the last two years has your family used any of the following services at UCSF BCH-SF?

☐Emergency Room

☐Outpatient Clinic

☐Children's Surgery Center

☐Inpatient (please check all units you have been in with your child)

☐ICN (3rd floor)
☐Pediatric ICU (4th floor)
☐Cardiac ICU (4th floor)
☐Cardiac Transitional Care Unit (4th floor)
☐Medical / Surgical Unit (5th floor)
☐Transitional Care Unit (5th floor)
☐Hematology / Oncology (6th floor)
☐Blood and Marrow Transplant (6th floor)

☐Radiology

☐Lab

☐Other (please specify) _____

THIS SECTION IS OPTIONAL. THE QUESTIONS ARE DESIGNED TO HELP US MAKE OUR COMMITTEES AS DIVERSE AS POSSIBLE:

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Other (please specify) _____

Primary Language Spoken: _____

What other language(s) do you speak (Check all that apply)

- ☐ American Sign Language
- ☐ English
- ☐ Spanish
- ☐ Cantonese
- ☐ Other (please specify) _____