



**FAMILY ADVISORY COUNCIL APPLICATION**

Children's Hospitals and Clinics of Minnesota

*Please contact the Council if you have any questions or need this application in another form,  
i.e., Language, Braille, or Spoken Word*

**Voicemail: 612-813-7407 Email: familyadvisorycouncil@childrensmn.org**

Today's date: \_\_\_\_\_

1. Your Name: \_\_\_\_\_

2. Home Address (street, city, state, zip code):  
\_\_\_\_\_

3. Phone Number: Daytime: \_\_\_\_\_ Evening: \_\_\_\_\_

4. Email Address: \_\_\_\_\_

5. Languages spoken in the home: \_\_\_\_\_

6. Occupation: \_\_\_\_\_

**\* Families who are recently bereaved are asked to wait two years after the death of their child before applying to the FAC.**

7. Name of child with health needs/experiences (if more than one child please add under question #9).

\_\_\_\_\_ Child's DOB: \_\_\_\_\_ Relation to you: \_\_\_\_\_

8. Child's Primary Diagnosis: \_\_\_\_\_

9. Other Children?  Yes (Please enter names and dates of birth.)  No

\_\_\_\_\_  
\_\_\_\_\_

10. What campus does your family primarily use? \_\_\_\_\_

Has your family used other Children's locations? (Check all that apply.)

Minneapolis  St. Paul  Minnetonka  Roseville  Maple Grove  Woodwinds

Has your family used a pediatric clinic aligned with Children's? (Check all that apply.)

Metropolitan Pediatric Specialists:  Edina  Burnsville  Shakopee

Northeast Pediatric Clinic:  Hugo

PACE Clinic:

Partners in Pediatrics:  Brooklyn Park  St. Louis Park  Maple Grove  Plymouth  Rogers

Other:  \_\_\_\_\_

11. Would you be able to make a commitment to attend a 2-hour meeting every month for a term of three years?  Yes  No

12. What medical services has your family used? (Check all that apply.) Check **Past Year** if you have used this service within the past year or **Ever** if you have ever used this service.

Past Year	Ever		Past Year	Ever	
<input type="checkbox"/>	<input type="checkbox"/>	Emergency Department	<input type="checkbox"/>	<input type="checkbox"/>	Hematology/Oncology
<input type="checkbox"/>	<input type="checkbox"/>	Inpatient Unit _____	<input type="checkbox"/>	<input type="checkbox"/>	Home Care or Hospice
<input type="checkbox"/>	<input type="checkbox"/>	Neonatal ICU	<input type="checkbox"/>	<input type="checkbox"/>	Immunology
<input type="checkbox"/>	<input type="checkbox"/>	Pediatric ICU	<input type="checkbox"/>	<input type="checkbox"/>	Integrative Medicine
<input type="checkbox"/>	<input type="checkbox"/>	Day/Outpatient Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Lab
<input type="checkbox"/>	<input type="checkbox"/>	Short Stay Unit (SSU)	<input type="checkbox"/>	<input type="checkbox"/>	Mother Baby (Mpls.)
<input type="checkbox"/>	<input type="checkbox"/>	Infant Care Center (ICC)	<input type="checkbox"/>	<input type="checkbox"/>	Nephrology
<input type="checkbox"/>	<input type="checkbox"/>	Special Care Nursery	<input type="checkbox"/>	<input type="checkbox"/>	Neurology
Specialty Services:			<input type="checkbox"/>	<input type="checkbox"/>	Neurosurgery
<input type="checkbox"/>	<input type="checkbox"/>	Adolescent Medicine	<input type="checkbox"/>	<input type="checkbox"/>	NICU follow up Clinic
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedics
<input type="checkbox"/>	<input type="checkbox"/>	Audiology	<input type="checkbox"/>	<input type="checkbox"/>	Pain Team/Palliative Care
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Pharmacy
<input type="checkbox"/>	<input type="checkbox"/>	Birth Center (St. Paul)	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry
<input type="checkbox"/>	<input type="checkbox"/>	Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	Psychology
<input type="checkbox"/>	<input type="checkbox"/>	Cath Lab	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory/Pulmonology
<input type="checkbox"/>	<input type="checkbox"/>	Cleft/Craniofacial Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Radiology
<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Lab/Clinic
<input type="checkbox"/>	<input type="checkbox"/>	Developmental Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Special Diagnostics
<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose and Throat	<input type="checkbox"/>	<input type="checkbox"/>	Trauma
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Urology
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy Clinic	Rehabilitation:		
<input type="checkbox"/>	<input type="checkbox"/>	Feeding Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Animal Assisted Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Gastroenterology/ GI	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	<input type="checkbox"/>	General Pediatric Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Genetics	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language Therapy

13. Have you used the following non-medical services? (Check all that apply.)

<input type="checkbox"/> Bereavement Services	<input type="checkbox"/> Ethics Consult	<input type="checkbox"/> MyChildren's
<input type="checkbox"/> Caring Bridge Web Site	<input type="checkbox"/> Family Resource Center	<input type="checkbox"/> Ronald McDonald House
<input type="checkbox"/> Chaplaincy	<input type="checkbox"/> Financial Counseling	<input type="checkbox"/> Sibling Play
<input type="checkbox"/> Child Life	<input type="checkbox"/> Geek Squad	<input type="checkbox"/> Social Work
<input type="checkbox"/> Children's Web Page	<input type="checkbox"/> Interpreter Services	<input type="checkbox"/> Other _____

14. Please tell us how you learned about the Family Advisory Council?

---



---

15. Why are you interested in joining the Family Advisory Council?

---



---

I acknowledge that I have provided accurate information to the best of my ability.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

*Please send the completed application to:*  
 Family Advisory Council – Mail Stop 70-503  
 Children's Hospitals and Clinics of Minnesota  
 345 North Smith Avenue  
 St. Paul, MN 55102