

Partners in Care Advisory Board Membership Application



Please indicate to which Council you are applying:

- Hospital-wide Advisory Board
- Cancer Advisory Board
- Children’s Services Advisory Board
- Medicine Advisory Board

Thank you for your interest in the Partners in Care Advisory Boards. Membership on either Board requires your successful completion of the registration process, including but not limited to: a health screening which includes TB testing, a criminal background check, a formal interview process, as well as a mandatory advisor orientation. All of your information will be treated as confidential. Membership on either Board requires attendance at monthly Board meetings. Advisory Board applicants must be 18 years of age or older. Advisors will demonstrate a readiness to help others, maintain respect for collaboration and assist SBUMC in delivering quality patient care.

Please **PRINT** all information clearly:

Name: Last	First
Home Address:	
City/State/Zip:	
Home Telephone #:	
Mobile Telephone #:	
Work Telephone #:	
E-mail Address:	
Date of Birth:	
Social Security #:	

Have you ever been convicted of a felony or misdemeanor? Yes No

If yes, provide date, charge, and disposition.

Authorization to Conduct Background Verification and General Release	
<p>In connection with my application to become an advisor at the Stony Brook Medical Center, hereafter “employer”, I hereby authorize the employer to conduct a background investigation pursuant to the Fair Credit Reporting Act which may include, but not limited to, a Social Security Number verification and Criminal Conviction verification. I also authorize the “employer” to conduct an Office of Inspector General (OIG) search to ascertain my current status with the OIG List of Sanctioned Individuals, and to conduct a General Services Administration (GSA) search of their List of Parties Excluded to ascertain my current status in the GSA.</p> <p>I am aware that I have the right under Fair Credit Reporting Act to request from the vendor performing the background check, the nature and scope of any report they have prepared in conjunction with the verifications conducted related to my application to be an advisor. I authorize and request all courts and law enforcement agencies to release such information without restriction or qualification.</p> <p>I hereby release Stony Brook University, Stony Brook University Medical Center, their respective officers, employees and agents, from any liability and responsibility arising from preparation of the above described background check, investigation or report, and any resulting outcome or consequences, as well as any liability and responsibility arising from obtaining, reviewing, discussing any information gathered in connection with a review of my application, and any resulting consequences.</p>	
Applicants Signature:	Date:

Please indicate if you are a:

Family member

Patient

If family member, what is relationship to patient? _____

What services did you/your family member's care involve? _____

Why would you like to become a member of the Advisory Board? _____

Comments related to treatment experience? _____

Acknowledgement & Authorization

I hereby affirm that this application and all documents submitted to me in connection with my application for an advisor contain no willful misrepresentations and that the information given by me is true and complete. I understand that any false statements or misleading omissions made by me in connection with my application, or in responding to any requests for information, can be sufficient grounds for my rejection as a candidate for an advisor or for my immediate termination and/ore referral for criminal prosecution.

I agree if accepted as an advisor to abide by all rules, policies and regulations of Stony Brook University. I certify that the information that I have provided is complete and accurate. I agree to abide by the guidelines of the Advisory Board, to respect patient confidentiality, and to uphold the traditions of SBUMC.

Applicants Signature:

Date:

Please return completed application to: Patient & Family Centered Care Office, Stony Brook University Medical Center, L13S-Rm 116, Stony Brook, NY 11794-7715 or fax to (631)444-6420.
You may contact the PFCC office via telephone at (631)444-7772.

Received by PFCC Office: _____