Patient and Family Advisory Council for Quality and Safety (PFACQS) Questionnaire

Applicant Information

Name: __________________________________________________________

Email address: ___________________________________________ Phone: _____________________________

Mailing address: ___________________________

City: ______________________ State: ___________ ZIP Code: __________

Please tell us about your experience at MedStar Health.

1. Have you ever been a patient of MedStar Physician Partners, MedStar Medical Group or MedStar Chesapeake CardioVascular Associates?
   □ Yes  □ No
   If your answer is YES, how long? ________________________________

2. Have you ever been a caregiver for a patient who was/is a patient of MedStar Physician Partners, MedStar Medical Group or MedStar Chesapeake CardioVascular Associates?
   □ Yes  □ No
   If your answer is YES, how long? ________________________________

3. Approximately how many times have you visited any of these practices over the last two years?
   ______________________________________________________________

4. How would you describe your experience at any of MedStar Physician Partners, MedStar Medical Group or MedStar Chesapeake CardioVascular Associates practices?
   ______________________________________________________________

5. What did the provider practices do well during your visit or your loved one’s visit?
   ______________________________________________________________

6. What could the practice have done better?
   ______________________________________________________________

If you need more room, please feel free to use additional pages. (continued on next page)
Please tell us more about you.

1. Do you volunteer in your community? If so, for which organizations?
__________________________________________________________________________________

2. Do you feel comfortable working in groups, speaking up and providing input?
__________________________________________________________________________________

3. Is English your first language?
   ☐ Yes ☐ No
   If No, what is your primary language?
   ________________________________________________________________________________

Eligibility Criteria:

1. Are you able to attend meetings at a MedStar Health facility during weekday evenings?
   ☐ Yes ☐ No

2. Are you willing to take the necessary immunizations to serve on the Patient Family Advisory Council for Quality and Safety?
   ☐ Yes ☐ No

3. Are you willing to sign an agreement promising not to disclose confidential information given to you in your role as a member of the Patient Family Advisory Council for Quality and Safety?
   ☐ Yes ☐ No

4. Are you willing to undergo a background check?
   ☐ Yes ☐ No

PLEASE RETURN YOUR COMPLETED APPLICATION TO:

MedStar Physician Partners
Attn: Quality Department
9600 Pulaski Park Dr., Suite 103
Baltimore, MD 21220