

Patient and Family Partner Volunteer Application

Please print or type your responses.

Today's Date:

Please check which eligibility criteria applies to you:

I have been an inpatient or outpatient at Walter Reed Bethesda within the last 3 years.

I am a family member of an inpatient or outpatient who received care at Walter Reed Bethesda within the last 3 years.

I am a current military, civilian or contract staff member at Walter Reed Bethesda.

First Name:

Last Name:

Street Address (Home):

City:

State:

Zip:

Home Phone:

Cell Phone:

Work Phone:

Is it ok to call you at work?

Yes

No

Number to call first:

Home

Cell

Work

Email Address:

Do you require any special accommodations?

How did you hear about this position?

Family/Friend

WRB Staff

WRB Website

WRB Social Media

WRB Signage

WRBtv

Secure Messaging

Other:

Do you volunteer for other organizations or this medical center in another capacity?

Yes

No

If yes, please explain:

Why do you want to be a part of the Patient and Family Partnership Council at Walter Reed Bethesda? Please add additional pages if you need more space.

Reference/Nomination

Please give the name of a personal or professional reference who we may contact.

Name:

Phone Number:

Relationship to You:

I understand that:

I may be required to participate in an interview for this position.

My health care will not be affected by my application or future participation.

Signature

Date

Thank you for your interest! If you have any questions or need additional information, please contact the Chief Experience Officer at **dha.bethesda.wrnmhc.list.experience@mail.mil**

**Please return this application to the above email address, or mail to:
WRNMMC, Chief Experience Officer, 8955 Wood Road, Building 1, 5th Floor, Rockville Pike,
Bethesda, MD 20889**