Children's Hospital *of* The King's Daughters

Kids as Partners Advisory Council

(KAPAC)

Membership Application Form

Date: _____

Name: _____

Age: _____ **Birth date:** _____

Home Address: _____

E-mail: _____**Preferred Phone Number:** _____

What is the best way to contact you? (Please circle) Phone E-mail

Best time to contact?_____

Did someone recommend you for council membership? (Please circle) Yes No

If yes, who?_____

Your Signature: _____

Parent/Caregiver's Name: _____

Parent/Caregiver's E-mail: _____

Parent/Caregiver's Preferred Phone Number: _____

Parent/Caregiver's Signature: _____

Please circle: Patient Sibling Both

Reason for hospitalization/medical conditions?

_____

_____

Clinics, units, and/or physicians I received care from?

_____

_____

Please list your past or current volunteer experience in the community and extracurricular activities at school?

_____

_____

_____

_____

What are some things that CHKD does well?

_____

_____

_____

_____

Do you have any ideas that you would want to bring to KAPAC and CHKD?

_____

_____

_____

_____

If you could change one thing at CHKD what would it be?

_____

_____

_____

_____

Name 3 words that describe you?

_____

_____

Anything else you would like us to know about you?

_____

_____

Please note: Each member is appointed to a one-year term. The Council meets once a month between September and May (excluding December) on the 1st Tuesday from 6:00-7:30pm. Dinner will be provided.

Please submit a letter of recommendation from a health system staff member or a school staff member. Please ask them to submit the letter via E-mail to KAPAC@chkd.org or mail it to:

Child Life Department
Attention: KAPAC
601 Children's Lane
Norfolk, VA 23507

Please use the same E-mail or mailing address to submit this application.