Family Advisory Board (FAB)

MEMBERSHIP APPLICATION

Name: ____
(Last) (First) (M.I.)

Address: ____
(Street) (City) (State) (Zip)

Home Phone :(____) _______________ Work Phone :(____) ________________________

E-mail address:____

Please briefly describe your experience with Driscoll Children's Hospital:

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Why are you interested in becoming more involved in Driscoll Children's Hospital?

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Do you have any improvements/ideas you would want to bring to Driscoll Children's Hospital?

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What are the names of your children who were cared for at Driscoll Children's Hospital and Clinics? What clinics, units, and/or physicians did they receive care from?

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(Last) (First) (M.I.) (age) (Clinic/unit/physician)

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(Last) (First) (M.I.) (age) (Clinic/unit/physician)

Please drop off this application in the Suggestion Boxes by the elevators or mail it to:
Robin Smith, Driscoll Children's Hospital 3533 South Alameda Street, Corpus Christi, Texas, 78411.

Please note that the information you enter into this form is confidential and will not be used or disseminated for any purpose other than as a tool to determine membership eligibility. Your application will be reviewed and you will be provided a response as quickly as possible. Thank you for your interest in serving Driscoll Children's Hospital.