

Patient and Family Advisory Council  
Nomination Form

Name of nominee: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Patient/Family Member:

Name	Services Used (ex. Inpatient, Outpatient, Ambulatory Surgery, Emergency Department, etc.)
_____	_____
_____	_____
_____	_____

I am recommending this patient and/or family member to be a member of the Patient and Family Advisory Council because:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of person making this recommendation:

\_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

**Send Completed Form To:**

Patient and Family Advisory Council  
Service Excellence  
Summa Health System  
525 East Market Street  
Akron, OH 44309  
servexc@summahealth.org

