

# Patient Advisor/Member Request for Participation

For Meeting(s) or Event(s)

## Name of Meeting or Event:

## Type of meeting or event (check all that apply):

One time event     Recurring meeting     If yes, how often  
 Conference     Panel     Committee     Meeting     Project  
In person     WebEx

Other: please describe \_\_\_\_\_

Date(s)	
Time(s) (start/end) (start end time of patient advisor's role)	
Location(s)	

## Requestor's Contact Information:

Name, Title, Role	
Work Phone	
Cell Phone	
e-Mail Address	

## Purpose of Meeting (please avoid acronyms, abbreviations and medical jargon):

## Reasons for Requesting Advisor:

## Advisor's Role in Meeting or Event (note if there is a speaking role):

## Please agree to provide the following before the meeting or event:

- Based on the member's preference; telephone call, email or meeting with the member to explain their role (**identify how we will know member's preference**)
  - Review of agenda, related documents, relevant background material

- Clarify any materials that have medical jargon, acronyms and abbreviations
- Answer any questions
- **Provide** details on the meeting location, date and time of event and notification if the event is cancelled or changed
- Identify any challenges that the member may be able to assist with
- Provide patient advisor bio as appropriate
- Identify a key contact to meet and greet the patient at the event
- Notify meeting attendees that an Advisor will be present and explain their role

**During and after the meeting or event, I or a designee agree to provide:**

- Patient advisor Introduction to the group and a warm welcome
- Explanation of Advisor's role to the group
- A designated person to sit next to Advisor as their guide and to answer questions and translate any healthcare terms
- Communication about next steps and/or outcomes of the meeting or event
- Thank you to Advisor
- Email survey or phone call (sent after the event) to gather their feedback on participation

**Reimbursement of costs to Advisors if travel outside of local area is involved:**

- We cannot reimburse the Member for travel costs related to this meeting
- We can reimburse the Member for travel costs related to meeting (check all that apply):
  - Mileage
  - Parking
  - Hotel
  - Airfare
  - Ground transportation
  - Meals
  - Honorarium or stipend (cannot exceed \$25.00 or tax applies)

Name and e-mail of contact person who will complete reimbursement process:

\_\_\_\_\_

**Alternate Contact Information**

Name, Title, Role	
e-mail and phone number	

**Any participant experiences or backgrounds that would be helpful for this meeting? Any to exclude? (Note that a limited number of Advisors are available at any time.)**

**Will Protected Health Information (PHI) or other proprietary information be discussed?**

- No
- Yes (signed confidentiality forms are required prior to event)

**Anything else you would like to add?**

**Agreement**

I agree to complete the items listed in this form. Signature: \_\_\_\_\_

**Submission**

Please scan or email this form to: \_\_\_\_\_

**Thank you!**

We appreciate your desire to collaborate with patients and families.

**To be completed by KP contact once Advisor is selected:**

Name(s) of member	
Preferred contact method	<input type="checkbox"/> e-mail <input type="checkbox"/> home phone <input type="checkbox"/> cell phone <input type="checkbox"/> work phone <input type="checkbox"/> text
Phone number(s)	
e-mail Address	

The above information is Protected Health Information (PHI), treat accordingly.