Henry Community Health

Partners Council Questionnaire

Name:_____

Address:_____

City:_____ State: _____ Zip Code:_____

Phone Number: _____ Email Address: _____

Check one:

- ☐ Male
- ☐ Female

- ☐ 18-30 years old
- ☐ 31-40 years old
- ☐ 41-50 years old
- ☐ 51-60 years old
- ☐ 61-70 years old
- ☐ 70 + years old

1. What is your experience with Henry Community Health (check all that apply)?

- ☐ Current patient
- ☐ Current patient's family member
- ☐ Current patient's caregiver

2. Please tell us about your experience with Henry Community Health. What impressed you? Where could we improve?

3. Please share any previous experiences you have had serving on a board or organizational committee (work, community, church, etc.):

4. What interests you the most about the possibility of serving on the Henry Community Health Partners Council?

5. Would you be able to commit to attending 4 meetings per year at Henry Community Health?

- ☐ Yes, absolutely
- ☐ I would definitely do my best to attend them all.
- ☐ I could probably only commit to 1 or 2.

6. What services within Henry Community Health have you or your family members used?

*Members of the Henry Community Health Partners Council are volunteers. If selected, you will need to: 1) attend an orientation meeting; 2) sign a confidentiality/privacy agreement. 3) Be up to date on Flu Vaccine.

Please submit your application via mail or email:

MAIL
Henry Community Health
ATTN: Patient & Family Advisory Committee
1000 North 16th Street
New Castle, IN 47362

EMAIL
info@hchcares.org