800 First Street, Suite 410
Macon, GA 31201
(478) 743-7068

CENTRAL GEORGIA | CANCER CARE

Passion for innovation, compassion for your care.

114 Sutherlin, Suite C-1
Warner Robins, GA 31088
(478)287-6144

Central Georgia Cancer Care

Patient and Family Advisory Council Application

Thank you for your interest in participating as a member of the Patient and Family Advisory Committee (PFAC) at Central Georgia Cancer Care (CGCC). This advisory council serves as a bridge between the patients, their families, and the healthcare team. PFACs are an integral part of the patient-centered care approach, where the voice and perspective of the patients and their families are valued.

Eligibility

You are eligible to apply if:

- You are age 18 or older
- You are a former or current patient treated at CGCC
- You are a family member or caregiver of a former or current patients treated at CGCC

Personal Information

FULL NAME:

ADDRESS:

CITY: **STATE:** **ZIP CODE:**

EMAIL: **TELEPHONE:**

Emergency Contact

FULL NAME:

RELATIONSHIP: **TELEPHONE:**

How did you learn about the PFAC program at CGCC?

800 First Street, Suite 410
Macon, GA 31201
(478) 743-7068

CENTRAL GEORGIA | CANCER CARE

Passion for innovation, compassion for your care.

114 Sutherlin, Suite C-1
Warner Robins, GA 31088
(478)287-6144

Why are you interested in becoming a member of the PFAC at CGCC?

Experience & Qualifications: Briefly describe any work experience, education, or skills that make you a suitable candidate for becoming a member of the PFAC at CGCC.

Is there anything else you would like to share that you believe would be valuable in your role as a PFAC member at CGCC?

Availability

DATE AVAILABLE TO START:

PREFERRED OFFICE LOCATION & TIME SLOTS:
(Select one or more)

☐ MACON ☐ WARNER ROBINS

☐ Morning (8:00 AM – 12:00 PM)

☐ Afternoon (1:00 PM – 5:00 PM)

☐ Other: ____________________________________

DAYS OF THE WEEK AVAILABLE:
(Check all that apply)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

REFERENCES

Please provide two references (name, phone number, email address) who can speak to your character and suitability for membership on the Patient and Family Advisory Council.

FULL NAME:

RELATIONSHIP: **TELEPHONE:**

FULL NAME:

RELATIONSHIP: **TELEPHONE:**

DISCLAIMER

I, the applicant, certify that my answers are true and honest to the best of my knowledge. I understand that any false or misleading information in my application or interview may result in my PFAC position being terminated. I also understand that this application does not guarantee a PFAC membership, and I am willing to comply with the policies and requirements of the CGCC PFAC Program.

FULL NAME: ____ **DATE:** ____________________

SIGNATURE: ____

Please complete and return this application to jobs@centralgacancercare.com