

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:

Mary Kay Rodgers
Service Excellence Department
Summa Health System
525 East Market Street
Akron, OH 44309
rodgersm@summahealth.org

