CSHP, A DaVita Medical Group
Patient Advisory Council Application

Thank you for volunteering to participate in the CSHP Patient Advisory Council. So that we can learn a little more about you and your interests, please complete this application and email to marketing@cshp.net.

Today's Date: _____ Daytime phone number: _____

Your Name: _____

Home Address: _____

I am a ☐ patient ☐ family member of a patient ☐ a patient AND a family member

I have been a patient with CSHP since _____ (year)

I have been seen: (Check all that apply)

☐ in primary care ☐ by a CSHP specialist ☐ in Urgent Care ☐ in the hospital

Tell us why you are interested in becoming a Patient Advisor:

Have you served as an advisor, volunteered, or served on a committee for other organizations, please share with us your experience in these roles:

Is there anything else you would like us to know?