chILD

CHILDRENS INTERSTITIAL AND DIFFUSE LUNG DISEASE FOUNDATION

PARENT ADVISORY COUNCIL (PAC) APPLICATION

The Parent Advisory Council is open to parents, caregivers of any relation, legal guardians, and/or patients over the age of 18. The selection of new members will depend upon the availability of a position on the Parent Advisory Council. The chILD Foundation's goal is to select individuals with a passion to help support patients and families that are impacted by chILD disorders. We will strive to elect PAC members from a variety of diagnoses and geographic regions with respect to our core values, mission and vision.

Applicants for chILD Foundation PAC membership are required to complete the following application and return it to: info@child-foundation.org

Name:		**Work Place:**
Address:		
City:		**Position:**
State:	**Zip:**	**Work Phone:**
Cell Phone:	**Fax:**	**Work Email (if different):**
Email:		**Preferred Contact Method (check all that apply):** ☐ Cell Phone (☐ Call ☐ Text) ☐ Email ☐ Work Phone ☐ Work Email
1. Explain why you wish to join the Parent Advisory Council (PAC) and actively participate in its functions.		
2. What special knowledge/qualities/expertise do you bring to the PAC that would help to support the goals and mission of the Foundation?		

3. Have you previously contributed to The chILD Foundation (financially, volunteer work, fund-raising, raise awareness, etc.)? If yes, please describe.

4. Give details of current knowledge of chILD Foundation-related activities.

5. Please list your involvement in other volunteer organizations both past and present:

6. Are you involved in any activities that could be construed as a conflict of interest? ☐ **No** ☐ **Yes**
If yes, please explain:

7. Are you available for evening conference calls? ☐ **Yes** ☐ **No**
Are you available during the daytime for calls? ☐ **Yes** ☐ **No**
Please explain any limitations or restrictions:

8. I am a parent or primary caregiver of a chILD patient. ☐ **Yes** ☐ **No**
I am a chILD patient over the age of 18 years. ☐ **Yes** ☐ **No**
(You must be one of the above to qualify for this council.)

9. Please check any areas of activities that you are particularly interested in:

- ☐ **Patient Education Planning**
- ☐ **Physician and Family Events Planning**
- ☐ **Liaison with your Local Physicians**
- ☐ **Fundraising Support**
- ☐ **Other:**
- ☐ **Research Program Planning**
- ☐ **Outreach and Advocacy**
- ☐ **Communication** (chILD e-Newsletter, Faces of chILD Calendar, etc)

References (please list one personal and one medical reference):		
Please list a personal reference:		
Name:		
Address:		
City:	**State:**	**Zip:**
Phone:	**Email:**	
Please list a medical reference:		
Name:		
Hospital/Clinic Affiliation:		
Medical Specialty:		
Email:		

Please attach any additional information you would like us to know about you.

As an active council member I am willing to commit additional time as needed.

Signature of Applicant: _____