Application Form for



MHP | MAJOR HEALTH | PARTNERS

Please submit completed application to:

Continued on back side

MHP Medical Center

Attn: Patient Experience/PFAC

2451 Intelliplex Drive

Shelbyville, IN 46176

or email to

PFAC@majorhospital.org

| Name: | | | | |
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| Address: | | | | * |
| City: | Stat | e: | <u></u> | Zip Code: |
| Home Phone: _ | | Cel | l Phone: _ | |
| Work Phone: | | Fax | 10 | |
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| Please check what days you | | | Please | Please check what times you | | | | |
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| | | Thursday | | | | | 2:00 p.m 4:00 p.m. | |
| | | Friday | | | | | 4:00 p.m 6:00 p.m. | |
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| Why | are V | ou interested in b | necomina a | Patient & | . Family | / Adv | risory Council member? | * |
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