



AT THE FOREFRONT OF **KIDS** MEDICINE™

**UChicago Medicine**

**Comer Children's**

## Teen Advisory Board Application

The Teen Advisory Board (TAB) acts as a voice for pediatric patients and families. The board consists of adolescents from eleven to seventeen years old who are, or have recently been, patients/siblings at our hospital. The purpose of the TAB is to recommend change that positively affects patient care at Comer Children's Hospital by providing pediatric patients and siblings an opportunity to voice their opinions, and help make the hospital more "kid-friendly."

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please indicate:

Patient       Sibling

Legal Guardian Name(s): \_\_\_\_\_

E-mail Address of Legal Guardian: \_\_\_\_\_

E-mail Address of Patient/Sibling: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

1. Please tell us about your racial and ethnic background. This will help us ensure diversity in the membership of the Teen Advisory Board.

What is your ethnic background?

- \_\_\_ Hispanic, Latino, or Spanish
- \_\_\_ Not of Hispanic, Latino, or Spanish origin
- \_\_\_ Mexican, Mexican American, Chicano
- \_\_\_ Puerto Rican
- \_\_\_ Cuban
- \_\_\_ Some other Hispanic, Latino, or Spanish origin
- \_\_\_ Do not know
- \_\_\_ Do not want to say

What is your race? (One or more can be checked)

American Indian/Alaska Native

White

Asian

Some other race

Black or African American

Do not know

Native Hawaiian/Other Pacific Islander

Do not want to say

2. Please tell us about the care you have received at Comer Children's Hospital

Have you been cared for at Comer:		Physician(s) you visit most regularly.
In the last 3 years?	Times per year?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> > 6	

3. How long have you/your sibling been associated with the hospital? \_\_\_\_\_

4. What clinics and programs have you been most involved with? (Please check all that apply)

Pediatric Intensive Care Unit (PICU)

Surgery

Comer 5<sup>th</sup> Floor

Pediatric Sedation

Comer 6<sup>th</sup> Floor

Special Procedures

Pediatric Specialty Clinics

Radiology

Emergency Department

Other \_\_\_\_\_

Comer Cancer Center

5. Are you open to sharing information about your experience(s) at Comer?

Yes

No

6. Are you involved in additional extra-curricular activities?

Yes, please indicate: \_\_\_\_\_

No

7. Are you able to attend meetings at the hospital on weekday evenings?

Yes

No

8. Please tell us 3 words that best describe you:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

9. Please tell us why you would like to be a member of our Teen Advisory Board:

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Thank You for Applying to be on the Teen Advisory Board

If you have questions about the Council call: **773-702-0407**

Please mail your completed application to:

Child Life and Family Education

Attn: Amy Carter

Comer Children's Hospital

5721. S. Maryland Ave.

Rm. K135, MC 8008

Chicago, IL 60637

Or you can:

**Email** your application to [amy.carter@uchosiptals.edu](mailto:amy.carter@uchosiptals.edu)

**Fax** your application to: 773-702-3812