

# Youth Advisor Application

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Dear Potential Youth Advisor,

Thank you for your interest in joining the ***Patient and Family Advisory Council*** as a Youth Advisor! The PFAC is made of two separate councils — the ***Family Advisory Council***, which is made up of parents and family members — and the ***Youth Advisory Council***, which is made up of current and former patients. Youth advisors are between 12-18 years old and have received care at The Bristol-Myers Squibb Children's Hospital or another hospital within the last 24 months (2 years). Excellent candidates to be youth advisors:

- Are motivated and excited to help other kids and teens
- Want to make a difference in the hospital
- Listen well
- Can speak comfortably in a group — including speaking with hospital staff
- Can work with people who are different from you/see different points of view
- Understand that changes in hospitals may take some time
- Are available to attend 1 meeting the 3<sup>rd</sup> Tuesday, every other month at 6:30 p.m.

Please complete this application and return it to the Family-Centered Care Coordinator. Once your **complete** application is received, the Family-Centered Care Coordinator will contact you **via email** to schedule a brief interview. Incomplete applications will not be considered, this includes the parental consent section.

We carefully consider each of the applications we receive and strive to have a balance of representation from all areas of the hospital. Please note that completion of the application does not guarantee acceptance as a youth advisor.

Completed applications can be emailed or mailed to:

April Slowenski, BS, MEd, CCLS, CPMT, IAC  
Family-Centered Care Coordinator  
[April.Slowenski@rwjbh.org](mailto:April.Slowenski@rwjbh.org)  
Bristol-Myers Squibb Children's Hospital at  
Robert Wood Johnson University Hospital  
1 Robert Wood Johnson Place  
New Brunswick, NJ 08901



Thank you for your willingness and interest in joining our team!

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## Eligibility Section

Please check all that apply:

- ☐ I am between 12-18 years old
- ☐ I received care (inpatient or outpatient) at BMSCH or another hospital within the last 2 years.
- ☐ I am able to attend YAC meetings on the 3<sup>rd</sup> Tuesday of the month at 6:30 p.m. every other month (January, March, May, July, September, November)
- ☐ I have parental consent to apply for and, if accepted, join the Youth Advisory Council (if under 18)

## Parental Consent:

*I permit my son/daughter to apply for and, if accepted, join the Youth Advisory Council at BMSCH, attending 1 meeting, the 3<sup>rd</sup> Tuesday of the month at 6:30 p.m., every other month (January, March, May, July, September, November). I understand a minimum of 1 year of service is required. I understand that most meetings will be held virtually using the Zoom app — with the possibility of 1 on-site meeting per year. I understand if my son/daughter misses 3 or more meetings they will be dismissed from the Youth Advisory Council. I assume responsibility for his/her transportation for any on-site meetings, understand the responsibilities involved, and will support my son/daughter in their youth advisor efforts.*

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Contact Number: \_\_\_\_\_

Print Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

- ☐ I am interested in joining the PFAC as a Family Advisor; please send an application to my email.

## Potential Youth Advisor Acknowledgement:

I acknowledge that (please check all to acknowledge):

- ☐ The YAC is separate from the volunteer department and by joining the YAC I am **not** considered a hospital volunteer, unless I have also completed the requirements of the volunteer department.
- ☐ Completing this application/interview process does not guarantee acceptance as a youth advisor.
- ☐ If accepted, I am committing to participate in 6 meetings per year, and I understand missing 3 or more meetings will result in dismissal from the council.
- ☐ Everything in this application is true and complete and I authorize RWJUH and/or its affiliated entities to investigate any and all statements I have made.

Potential Youth Advisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## General Information

Name: \_\_\_\_\_

Preferred Name/Nickname: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

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

City, State, ZIP: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address\*: \_\_\_\_\_

Emergency Contact Name & Number: \_\_\_\_\_

\*Email is the primary method for communication with the Patient & Family Advisory Council. Please provide the email that you will check most frequently.

## BMSCH Experience

Please share some information regarding your **most recent** experiences at BMSCH. This will allow us to determine the best candidates for the YAC at this time.

**1. I received care on the following units (select all that apply):**

- ☐ Pediatrics Unit
- ☐ Adolescent Unit
- ☐ Hematology/Oncology Unit
- ☐ PICU
- ☐ Same Day Surgery Center
- ☐ Other: \_\_\_\_\_

**2. My most recent care was in (month/year):** \_\_\_\_\_

**3. Briefly comment on why you are interested in becoming a Youth Advisor:**

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**4. What was the best thing about the care you received at BMSCH?**

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**5. What was the most challenging thing about the care you received BMSCH?**

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**6. If you had a magic wand and could change or improve one thing about healthcare at BMSCH, what would you change?**

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**7. Please share any hobbies, experience or skills that may help you in your role as a Youth Advisor:**

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**8. Please list any possible conflicts that may prevent you from attending YAC meetings consistently** (sports, extracurricular activities, part time job etc.)

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**9. Do you have an interest in working in healthcare in the future?** (this question will not impact acceptance but will help us choose special guest speakers to meet the interest areas of the council)

- ☐ Yes I want to work in healthcare
- ☐ No I do not want to work in healthcare
- ☐ I don't know

**If yes please indicate your areas of interest** (check all that apply)

- ☐ Nurse/Doctor/PA/Tech, etc.
- ☐ Child Life/Social Work/Art Therapy/Music Therapy, etc.
- ☐ Physical Therapy/Occupational Therapy/Speech Therapy, etc.
- ☐ Administration/Business/Finance/Human Resources, etc.
- ☐ Pastoral Care/Patient Experience
- ☐ Other: \_\_\_\_\_

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<b>Family-Centered Care Coordinator Use Only</b>
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**Interview Date:** \_\_\_\_\_ **Accepted:** Yes / No **Notified On:** \_\_\_\_\_

**If Accepted:**

- ☐ Orientation Date: \_\_\_\_\_
- ☐ Orientation Handbook Reviewed
- ☐ Orientation Attestation Signed
- ☐ Non-Disclosure Agreement Signed
- ☐ Parent Consent Confirmed
- ☐ First Meeting Date: \_\_\_\_\_

**If Not Accepted:**

- ☐ Date Informed \_\_\_\_\_
- ☐ Method: \_\_\_\_\_