Teen Advisory Board's
MEMBERSHIP APPLICATION

Name: _____
(Last) (First) (M.I.)

Address: _____
(Street)

_____
(City/State/Zip)

Home Phone:(____)_____ **Email Address:** _____

Birthdate: _____

Board interest please circle: Teen Advisory Board (TAB) or Hem/Onc Teens (HOT)

What diagnosis are you seen at Children's Mercy Hospitals and Clinic for?
_____**When were you first diagnosed?** _____

What clinics, units, and/or physicians have you received care from at Children's Mercy? _____

_____

Please tell us one Children's Mercy staff member we can contact for a recommendation: _____**Department**:_____

Please briefly describe your experience with Children's Mercy:

_____

_____

Why are you interested in becoming a TAB member?

_____

_____

Do you have any improvements/ideas you would want to bring to TAB and Children's Mercy? (**Please circle one) **YES or NO or NOT RIGHT NOW**
If so, please briefly explain:

_____

_____

What volunteer experiences do you have either at CMH or in your community?

_____

_____

Please drop off this application in the Volunteer Services Department or mail it to: Melissa Pulis, Child Life, Children's Mercy Hospitals and Clinics, 2401 Gillham Road, Kansas City, MO 64108

Please note that the information you enter into this form will be held in the strictest of confidence and will not be used or disseminated for any purpose other than as a tool to determine membership eligibility. TAB will review your application and provide a response as quickly as possible. Thank you for your interest.