HOLY CROSS REHABILITATION & NURSING CENTER
FAMILY COUNCIL

People who care most
Working together to promote
The Best Care

MEMBERSHIP FORM

Family Member: ____

Address: :____

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Home Phone:____________________ **Work Phone:**____________________

Resident:____

Room ____________ **Wing:**____________

Other Family Members who plan to participate in the Family Council:

Name: ____

Address: : ____

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Home Phone:____________________ **Work Phone:**____________________

Interest/Skills that you would be willing to share with Family Council:

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____

Topics you would like presented at Family Council meetings:

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Would you be willing to serve on a Committee or as a Wing Representative? **Yes** ☐ **No** ☐

Would someone else in your family be willing to serve on a Committee or as a Wing Representative? **Yes** ☐ **No** ☐

Voluntary Dues are $25.00 per year.
This includes all family members of a resident.