

Patient Testimonial Information Form



Thank you for choosing to share your story of exceptional care with us! In addition to the completion of this form, here is what you can expect throughout this process: You may be contacted by Influence Marketing MHCC's website partner, to make sure your story is told accurately and represented to your satisfaction.

We welcome any questions you may have and thank you again for sharing your story!

Submitter's Name: _____

Patient's Name (if different than Submitter): _____

Date of Birth: _____

Contact Information & Phone Number: _____

Email Address: _____

Date of Treatment/Experience: _____

Which clinic/department of MHCC did your treatment/experience occur?

Which staff (providers, nurses, CNA's, reception, etc.) would you like to mention in your testimony?

Story Description: (Add additional pages as necessary)

Why would you recommend MHCC?

I hereby consent, as a patient, employee, affiliate, or friend of Memorial Hospital of Carbon County, to being photographed and/or filmed and/or interviewed as Memorial Hospital of Carbon County. I hereby give my permission to use statements, photographs, films, and information for radio, television, print, electronic media, social media, website, and/or educational materials for publicity or advertising campaigns.

Signature of Participant/Parent/Guardian

Date

Return completed form to:

Lisa Hardy, Patient Advocate

Lisa.hardy@imhcc.com

Questions? Call 307-324-8314