



THE HEALTH CARE IMPROVEMENT FOUNDATION  
*Building Partnerships For Better Health Care*

PREVENTING AVOIDABLE EPISODES



Smoothing the Path for Better Transitions

## WORKGROUP PARTICIPANT DESIGNATION FORM

Please provide the requested information for each workgroup participant. Fax or email this completed form to: Patty Yurchick at 215-563-2442 or [pyurchick@hcifonline.org](mailto:pyurchick@hcifonline.org).

**Select One Workgroup:**

Medication Management       Personal Health Record       Coaching/Hand-offs

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

Organization: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Select One Workgroup:**

Medication Management       Personal Health Record       Coaching/Hand-offs

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

Organization: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Select One Workgroup:**

Medication Management       Personal Health Record       Coaching/Hand-offs

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

Organization: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Select One Workgroup:**

Medication Management       Personal Health Record       Coaching/Hand-offs

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

Organization: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_