**I have received a copy of the Patient Experience, Culture of Service & Service Excellence Expectations, Service Behaviors and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Overview materials.**

**I acknowledge and understand that I am representing WHITTIER HOSPITAL MEDICAL CENTER as a member of the Healthcare Team. I understand that I am expected to abide by all of the Service Behaviors listed and present myself in a professional manner at all times.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PRINT NAME SIGNATURE

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

DATE SIGNED SCHOOL AFFILIATION

**Return Acknowledgement to Administration**