



Mankato Clinic

Together we thrive.

PATIENT PARTNER ADVISORY COUNCIL

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: () _____ Evening Phone: () _____

Best time to call: _____ E-mail address: _____

I prefer being contacted via (check one): _____PHONE _____E-MAIL

The following questions are designed to help us get to know our potential Patient/Family partners better, and to help us build a diverse group of volunteers. All answers will be kept confidential.

Race/Ethnicity: Hispanic/Latino _____ Native American _____ Asian _____
African American/Black _____ White _____ Other _____

Primary language spoken: _____ Gender: Male _____ Female _____

What is the highest school level completed?

High School/GED _____ Some College _____ College Graduate _____ Master's Degree _____ PHD _____

Age Range: 18-30 _____ 31-50 _____ 51-65 _____ 66+ _____

Do you or your spouse/partner work for the Mankato Clinic or any of its affiliates?

YES _____ NO _____

Do any of your family members work for the Mankato Clinic or any of its affiliates?

YES _____ NO _____

If yes, please describe your relationship: _____

Do you have children under age 18? YES _____ NO _____ (If yes, please list below)

	<i>Name of Child</i>	<i>Age of Child</i>
Child(ren):	_____	_____
	_____	_____
	_____	_____

PATIENT/FAMILY ADVISORY COUNCIL

Are you a caregiver for any other family member or friend? YES____ NO____ If yes, please explain your situation: _____

What clinic do you (and/or your family) receive most of your health care: _____

Who is your Primary Care Provider? _____

What health care issues interest you most? (Check all that apply):

Prevention ____ Chronic Diseases _____ Elder Care ____ Affordability ____ Behavioral Health ____
Family Medicine ____ Pediatrics _____ Oncology ____ Patient Experience _____ Other _____

Please describe your availability (specify days of the week and hours of the day): _____

1. Do you have areas of special interest or expertise to offer? If yes, please explain.
2. What do you hope to contribute to the Patients/Family Advisory Council?
3. Is there anything else you would like us to know about you or your healthcare experience?

I understand that completion of this Form does not bind the candidate or the program coordinators in any way. The Patient/Family Advisory Council coordinators will choose participants that best meet the needs of the program and assign them accordingly. Before participating in the Council you will be required to complete a formal training program.

Signature _____

Date _____

Please mail or e-mail Partner Form to:

Marcia Bahr
Mankato Clinic
1400 Madison Ave. Suite 324B
Mankato, MN 56001

MarciaB@mankatoclinic.com

Once your Partner Form has been received we will contact you.
For additional questions call Marcia Bahr at 507-389-8770.

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