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 ____
Transgender ____ Genderfluid ____
Non-binary ____ Prefer not to answer ____

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 age(s) below)

Age of 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.