

## Patient and Family Advisor Application

### Contact Information

Name	
Address	
Phone Number(s)	
E-Mail Address	

### The following questions will help us get to know you a little better.

Are you a...  Patient  Family member  Caregiver?

When was your last care experience at Mid Dakota Clinic?

2017 to present  2016  2015  2014 or before

Which Mid Dakota Clinic location do you most often visit for Primary Care?

- Main Clinic at 9<sup>th</sup> & Rosser  
 Kirkwood Mall Clinic  
 Gateway Mall Clinic

We recognize that our patient and family advisors have busy lives. How much time are you able to commit to being an advisor? (Check one)

- Less than 1 hour per month  3-4 hours per month  
 1-2 hours per month  More than 4 hours per month

Are you able to serve as an advisor for at least 1 year? (You can still be an advisor if you answer “no”)

- Yes  No

How do you want to help? I want to.... (Check all of your interest areas.)

- Serve as a member of the patient and family advisory council. Potential members should be ready to commit to serving on the council for at least 1 year. The council meets about once every quarter.  
 Help develop or review informational materials for patient and family members.  
 Help improve patient safety.  
 Help improve the patient and family role in decision making  
 Help improve the clinic facilities (for example, waiting areas and patient care areas).  
 Review procedures and provide input to improve check-in process.  
 Other \_\_\_\_\_

### Please tell us about yourself.

Why do you want to become a patient and family advisor?

Please describe any specific things that doctors or clinic staff did or said while you or your family members were seen at the clinic that was helpful to you or your family.

Please describe any specific things that doctors and clinic staff could have done differently to be more helpful while you or your family member were seen at the clinic.

Our patient and family advisors reflect the diversity of the patients and families that we serve. Please share anything about yourself that you think would add to the diversity of our team of advisors.

#### Previous Volunteer Experience

Please briefly describe any experience you may have as an advisor, active volunteer, leader or public speaker.

#### Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

Name (printed)	
Signature	
Date	

#### Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in the Mid Dakota Clinic Patient and Family Advisory Council.

Please return form by dropping it off at any Mid Dakota Clinic registration desk, mailing it to the address provided below, or by emailing the application to [PFAC@middakotaclinic.com](mailto:PFAC@middakotaclinic.com)

**Attn: Karla Smith**  
**Mid Dakota Clinic**  
**PO Box 5538**  
**Bismarck, ND 58506**