Patient & Family Advisory Council Application

Are you interested in shaping how we provide care at Grand Itasca Clinic & Hospital? We recognize there are opportunities to improve on our service, and we appreciate your willingness to share your experiences. Please complete the below application and return it to the Quality Department, or the Volunteer/Information Desk. Thank you for your interest in helping us improve patient care at Grand Itasca!

First Name: _____ Last Name: _____

Daytime Phone: _____ Email: _____

Are you an Itasca County resident? Y N

Are you a current or past Grand Itasca employee? Y N

Have you been a Grand Itasca patient? ☐ Inpatient ☐ Outpatient ☐ Both

Are you willing to consent to our confidentiality and privacy laws? Y N

I wish to provide feedback for the following departments: *(please check all that apply)*

☐ Reception/Registration Clinic ☐ Unit 1 ☐ Unit 2 ☐ Unit 3 ☐ Unit 4 ☐ Urology

☐ Emergency Department ☐ ICU ☐ Med/Surg/Peds ☐ Women's Health/Birth

☐ Rapid Clinic ☐ YMCA Clinic ☐ Retail Pharmacy ☐ Day Surgery

☐ Rehabilitative Services ☐ Release of Information ☐ Business Office

☐ Lab Services ☐ Diagnostic/Imaging ☐ Infusion ☐ Other: _____

Are there any specific topics you'd like to provide feedback about?

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