Winona Health

Patient Experience Advisory Committee Membership Application

Winona Health's Patient Experience Advisory Committee, E-Advisor Program, and Real-Time Patient Experience process plays an important role in our commitment to deliver compassionate patient-centered care. As an Advisory Committee Member, you will be the voice of other patients, families and caregivers by sharing your thoughts on how we at Winona Health can better understand priority health issues, improve people's care experience, and streamline communications.

Please complete this form if you are interested in being considered for this committee.

Name: _____

Address: _____

City, State, Zip Code: _____

Primary Contact Number: _____

Email Address: _____

Age Range:

- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65+

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Other

Are you or the person you care for a Winona Health patient? (check all that apply):

- ☐ Current patient (within the past year)
- ☐ Past patient (more than a year ago)
- ☐ Family Member of current patient
- ☐ Family Member of past patient

Which departments have you or the person you care for had an appointment in within the past year?

- ☐ Primary Care
- ☐ Emergency Care
- ☐ Urgent Care /Quick Care
- ☐ General Surgery
- ☐ Eye Care
- ☐ Radiology
- ☐ Lab
- ☐ Podiatry
- ☐ Audiology
- ☐ Orthopedics
- ☐ Obstetrics & Gynecology
- ☐ Rehabilitation Services (PT, OT, Speech, Cardiac Rehab)
- ☐ Infusion Therapy
- ☐ Hospice
- ☐ Pediatrics
- ☐ Senior Services (assisted living, nursing home)
- ☐ Dialysis
- ☐ Plastics, Dermatology and/or Spa
- ☐ Other: _____

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Winona Health

Please disclose any conflicts of interest (e.g., personal or professional relationships with people at Winona Health or any other healthcare organization):

_____

_____

_____

Why would you like to be on the Patient Experience Advisory Committee?

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_____

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_____

Please check which group(s) you are interested in participating in:

☐ **Patient Experience Advisory Committee:** Meet with other patients, family members, and Winona Health caregivers to provide feedback on defined topics each meeting.
(1-2 hours per month)

☐ **E-Advisor Program**: Answer electronic surveys to provide feedback about your ideal healthcare experience and your experience at Winona Health.
(15 minutes per survey, no more than 2 surveys per month)

☐ **Real Time Patient Experience**: Provide feedback on your experience shortly after your service at Winona Health.
(15-30 minutes per survey, depending on the level of detail you provide)

Your Signature _____ **Date** _____

Complete the application online, or return your completed application by mail or email to:
Community Relations
Attn: Patient Experience
855 Mankato Avenue
Winona, MN 55987

patientexperience@winonahealth.org

For additional information, please visit our website at www.winonahealth.org/experience.