Patient Advisory Council
Subject Matter Expert
APPLICATION

About You:

I am (Check one): ◯ Patient ◯ Family/Caregiver ◯ Stakeholder

FIRST NAME: _____ LAST NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ EMAIL: _____

I identify as:
- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black/African American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White
- ◯ Other _____

Ethnicity: I identify myself as: ◯ Hispanic/Latino ◯ Not Hispanic or Latino

I mainly speak:
- ◯ English
- ◯ Spanish
- ◯ Other _____

About your ESRD Experience:

Dialysis Facility Name: _____

Dialysis Facility Phone Number: _____

Name of Referring Staff Member: (must be included if staff member is referring candidate) _____

Number of Years as an ESRD patient: _____

Current Treatment Type (check one):

- ◯ In-Center Hemodialysis
- ◯ Peritoneal Dialysis
- ◯ Home Hemodialysis
- ◯ Transplant

If you are an In-Center Patient, please choose your treatment day schedule:

- ◯ M/W/F
- ◯ T/T/S

If you are a transplant recipient, please give us the Number of years You have had the transplant:

Previous Treatment Types:
(Check all that apply)

- ☐ In-Center Hemodialysis
- ☐ Peritoneal Dialysis
- ☐ Home Hemodialysis
- ☐ Transplant

Are you on the Transplant Waitlist?:

- ◯ Yes
- ◯ No

Connecting with You

Preferred Method of Contact:

- ☐ Phone
- ☐ Email
- ☐ Mail

How often do you check your email (check one):

- ◯ Daily
- ◯ 2-3 times/week
- ◯ only when expecting important messages
- ◯ Don't have email

Are you able to attend 2 or more meetings by phone per year?

- ◯ Yes
- ◯ No

Please read the following statements (all must be checked to be considered):

PAC member responsibilities can be found here: http://www.therenalnetwork.org/about/patientlead.html

- [ ] I have read the PAC member responsibilities and participation/membership policy and agree to fulfill them to the best of my ability.
- [ ] I authorize the The Renal Network and my dialysis center (if applicable) to utilize my name and email address for specific PAC and SME communications.
- [ ] I further authorize my Network to use my name where necessary in PAC and SME meeting minutes and in listing PAC and SME members in reports to the Centers for Medicare and Medicaid Services (CMS) and other business documentation.

Applicant Signature: Date:

Staff Signature (if Applicable): Date:

Please Submit completed form to The Renal Network in one of the following ways:

Email to: cbarbee@nw10.esrd.net

Fax to: 317-275-2088

Mail to: c/o Caprisheus Barbee, 911 East 86th Street, Suite 202, Indianapolis, IN 46240

If you have any questions, please contact The Renal Network at 1-800-456-6919