

Patient Advisory Council Member Application Form

Please complete the following information for consideration to participate on the Network Patient Advisory Council (PAC).

ABOUT YOU	
I am (check one):	<input type="checkbox"/> Patient <input type="checkbox"/> Family/Caregiver <input type="checkbox"/> Stakeholder
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	
Email Address	
I identify as:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other
Ethnicity, I identify myself as:	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic or Latino
I mainly speak:	<input type="checkbox"/> English <input type="checkbox"/> 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 a Dialysis Patient	
Current Treatment Type: (check one)	<input type="checkbox"/> In-Center Hemodialysis: M/W/F or T/T/S <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant, if yes, number of years as a transplant recipient _____
Previous Treatment Types: (check all that apply)	<input type="checkbox"/> In-Center Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant
Are you on a transplant waitlist? (circle one)	<input type="checkbox"/> Yes <input type="checkbox"/> 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 travel out of state for face-to-face meetings?	___ Yes ___ No
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*):

- 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 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:** _____

Submit completed form to ESRD Network 16. You may fax it to 206-923-0716.

If you have any questions you may email our Patient Services Director at

LLHall@comagine.org or by phone at 800-262-1514.

(Note: If we receive more applications than we have slots available, we may refer to your application at a later date, if additional SME participants are needed.)