

Patient Subject Matter Expert Application Form

Please complete the following information for consideration to participate on the Network Patient Advisory Council (PAC) and/or as a Network Patient Subject Matter Expert.

| 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 (Please have your Social Worker call the Network) | |
| 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 | <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail |
| How often do you check your email (check one): | <input type="checkbox"/> daily <input type="checkbox"/> 2-3 times/week <input type="checkbox"/> only when expecting important messages <input type="checkbox"/> don't have email |
| Are you able to travel out of state for face- to-face meetings? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you able to attend 2 or more meetings by phone per year? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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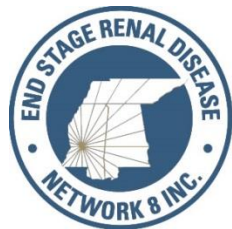
Please read the following statements (*all must be checked*):

- I have read the PAC member responsibilities and participation/membership policy and agree to fulfill them to the best of my ability.
- I authorize 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 the completed form to Network 8. You may fax it to 601-932-4446 or mail it to 775 Woodlands Pkwy, Suite 310, Ridgeland, MS 39157. If you have any questions, please contact us at 1-877-936-9260.



END STAGE RENAL DISEASE
NETWORK 8, INC.