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):	____Patient____Family/Caregiver____Stakeholder
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	
Email Address	
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 (**Please have your Social Worker call the Network**)	
Number of Years as a Dialysis Patient	
Current Treatment Type: (check one)	____In-Center Hemodialysis: M/W/F or T/T/S ____Peritoneal Dialysis ___Home Hemodialysis ____Transplant, if yes, number of years as a transplant recipient_____
Previous Treatment Types: (check all that apply)	____In-Center Hemodialysis ____Peritoneal Dialysis_____Home Hemodialysis ____Transplant
Are you on a transplant waitlist? (circle one)	____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 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

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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.