Comagine Health
ESRD ALLIANCE | NETWORK 18

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):	____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 (must be included if staff member is referring candidate)	
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

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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 18. You may fax it to 888-280-8669.
If you have any questions you may email our Patient Services Director at ERhodes@comagine.org or by phone at 800-637-4767.

(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.)