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 (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
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 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:** _____

Please submit completed form to the Network by **December 31, 2017**.
You may fax it to 203-389-9902 or mail it to:
IPRO ESRD Network of New England
1952 Whitney Avenue, 2nd Floor, Hamden, CT 06517

If you have any questions, please contact us toll free at 866-286-3773.

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