End-Stage Renal Disease Network of New York
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 209-5578
esrd.ipro.org

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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
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__

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Previous Treatment Types: (check all that apply)	____In-Center Hemodialysis ____Peritoneal Dialysis___Home Hemodialysis
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

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.

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Applicant Signature ____

DATE: __________________

Staff Signature (if Applicable): _____________________________

DATE: _________________

Submit completed form to Network 2. You may fax it to 516-326-8929 or mail it to 1979 Marcus Avenue, Suite 105, Lake Success, NY 11042. If you have any questions, please contact us at (800)238-3773.

(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.)