

Patient Advisory Council Application Form

Patient Advisory Council Members (PAC) are a group of patients, caregivers, and family members that partner with the Network to serve patients, improve facility outcomes, and seek ways to improve patient/staff relationships. The PAC assists the Network to identify ways to spread best practices as well as design/implement Quality Improvement Activities (QIAs) to promote patient-empowerment and engagement.

Complete the following information:

About You	
I am (check one):	☐ Patient ☐ Family/Caregiver
If not a patient, is the patient in your life:	☐ Adult ☐ Pediatric (☐ Age of Pediatric Patient)
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	
Secondary Phone/ Cell Phone	
Email Address	
About Your ESRD Experience	
Dialysis Facility Name	
Dialysis Facility Phone Number	
Number of years as a dialysis patient	
Number of years as a transplant recipient (as applicable)	
Current Treatment Type: (check one)	☐ In-Center Hemodialysis: M/W/F or T/T/S ☐ Peritoneal Dialysis ☐ Home Hemodialysis ☐ Transplant
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	
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 attend 3 or more meetings by phone per year?	Yes No
Your ESRD Expertise	
Why would you like to join the Patient Advisory Council (PAC)?	
Your Interests: Which project(s) would you enjoy working on? (check all that apply)	
Patient and Family Engagement: Assist the Network in developing education and initiatives to increase patient and family involvement in their own care	☐
Hospitalization: Reduce hospitalizations for patients	☐
Kidney Transplant: Help increase number of dialysis patients receiving a transplant	☐
Vaccinations: Share your ideas on ways to encourage patients to accept recommended vaccinations	☐
Home Dialysis: Help the Network understand how to educate patients on home therapy programs	☐

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Please read and check the appropriate statements below:

_____ I authorize AHS/Network 7, 8, 13 and/or 14 to utilize my name and email address for specific Patient Advisory Council communications.

_____ I further authorize AHS/Network 7, 8, 13 and/or 14 to use my name where necessary in meeting minutes, and in listing PAC member names in reports to The Centers for Medicare and Medicaid Services (CMS).

Signature of Candidate: _____ Date: _____

Name of Candidate (print): _____

Submit completed form to the appropriate Network. Allow 5-10 business days for processing and follow-up.

ESRD Network 7 & 8
(Florida, Alabama, Mississippi, Tennessee)
Fax #: 601-932-4446

ESRD Network 13 & 14
(Arkansas, Louisiana, Oklahoma, Texas)
Fax #: 972-503-3219

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