Quality Insights
Renal Network 5

PATIENT & FAMILY ADVISORY COMMITTEE (PFAC) ENROLLMENT FORM

About You	
Your Name	
Street Address	
City, State, Zip	
Phone	
E-Mail	
Race/Ethnicity	❑ American Indian or Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Preferred Language	❑ English ❑ Spanish ❑ Other
Relationship to Person with Renal Disease	❑ Patient ❑ Family/Care Partner
What is your work/volunteer experience?	
Other interests, hobbies, or skills:	

About Your ESRD Experience	
Dialysis Facility Name	
Current Treatment Type	❑ In-Center Hemodialysis ❑ Peritoneal Dialysis ❑ Home Hemodialysis ❑ Transplant
Have you done other types of treatment?	❑ In-Center Hemodialysis ❑ Peritoneal Dialysis ❑ Home Hemodialysis ❑ Transplant
How many years have you been an ESRD patient?	

Connecting with You	
Preferred Method of Contact	❑ Phone ❑ Email ❑ Mail
Which project topic(s) would you be interesting in working on with a group?	*(check all that apply):* ❑ Infections ❑ Home Treatment ❑ Mental Health (Depression) ❑ Transplant ❑ Nursing Home ❑ Patient and Family Engagement in Facilities ❑ Vaccinations

Return to:

Quality Insights Renal Network 5
PO Box 29274, Henrico, VA 23242
Fax: 804.320.5918 * Toll-free # 866.651.6272

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 Quality Insights Renal Network 5 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:_____

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