



About You	
<b>Your Name</b>	
<b>Street Address</b>	
<b>City, State, Zip</b>	
<b>Phone</b>	
<b>E-Mail</b>	
<b>Race/Ethnicity</b>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other  <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
<b>Preferred Language</b>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other
<b>Relationship to Person with Renal Disease</b>	<input type="checkbox"/> Patient <input type="checkbox"/> Family/Care Partner
<b>Why would you like to serve on this committee?</b>	
<b>What is your work/volunteer experience?</b>	
<b>Other interests, hobbies, or skills:</b>	

About Your ESRD Experience	
<b>Dialysis Facility Name</b>	
<b>Current Treatment Type</b>	<input type="checkbox"/> In-Center Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant
<b>Have you done other types of treatment?</b>	<input type="checkbox"/> In-Center Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant
<b>How many years have you been an ESRD patient?</b>	
<b>Are you on a transplant wait-list?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Connecting with You	
<b>Preferred Method of Contact</b>	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail
<b>Which project topic(s) would you be interesting in working on with a group?</b>	<i>(check all that apply):</i> <input type="checkbox"/> Grievances <input type="checkbox"/> Infections <input type="checkbox"/> Home Treatment <input type="checkbox"/> Mental Health (Depression) <input type="checkbox"/> Transplant <input type="checkbox"/> Vocational Rehabilitation



**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: \_\_\_\_\_

Return to:

---

Quality Insights Renal Network 5  
300 Arboretum Place, Suite 310, Richmond, VA 23236  
Fax: 804.320.5918 \* email: [rbovacollis@nw5.esrd.net](mailto:rbovacollis@nw5.esrd.net) \* Toll-free # 866.651.6272