

ESRD NETWORK OF NEW ENGLAND
PATIENT ADVISORY COMMITTEE (PAC)
PATIENT APPLICATION FORM

Your Name	
Street Address	
City, State	
Zip Code	
Phone	
E-Mail	

Dialysis/Transplant Facility Name	
Current Dialysis Facility Treatment Type	<i>(circle one):</i> In-Center Hemodialysis Peritoneal Dialysis Home Hemodialysis Transplant
Have you had other types of Treatment?	<i>(circle):</i> In-Center Hemodialysis Peritoneal Dialysis Home Hemodialysis Transplant
Years as a patient	
Would you be able to attend two(2) meetings a year in the Sturbridge, MA area? (Travel is reimbursed)	<i>(circle one):</i> Yes No

PLEASE COMPLETE THE REVERSE-SIDE OF THIS APPLICATION

Why would you like to serve on this committee?

Other interests, hobbies, or skills:

Can we contact your dialysis facility to verify this information?

(circle one):

Yes No

The following information is **NOT REQUIRED** but would be helpful in learning more about you.

What is your work experience?

Have you volunteered on other committees?

Please provide 1 or 2 statements about yourself that you would like to share with others.