



Midwest Kidney Network (ESRD Network 11)
 2901 Metro Drive, Suite 400
 Bloomington, MN 55425
 Phone: 800-973-3773 Fax: 651-644-9853
 www.midwestkidneynetwork.org

Patient Subject Matter Expert Application Form

Please complete the following information for consideration to participate as a Network Patient Subject Matter Expert.

About You	
I am (check one):	<input type="checkbox"/> Patient <input type="checkbox"/> Family/Caregiver <input type="checkbox"/> Stakeholder
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	
Email Address	
I identify as:	<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
Ethnicity: I identify myself as	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic or Latino
I mainly speak:	<input type="checkbox"/> English <input type="checkbox"/> 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)	<input type="checkbox"/> In-Center Hemodialysis: M/W/F or T/T/S <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant, if yes, number of years as a transplant recipient _____
Previous Treatment Types: (check all that apply)	<input type="checkbox"/> In-Center Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant
Are you on a transplant waitlist? (circle one)	Yes No
Connecting With You	
Preferred Method of Contact	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail

How often do you check your email (check one):	<input type="checkbox"/> daily	
	<input type="checkbox"/> 2-3 times/week	
	<input type="checkbox"/> only when expecting important messages	
	<input type="checkbox"/> 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 authorize the Network 11 and my dialysis center (*if applicable*) to utilize my name and email address for specific Patient Subject Matter Expert communications.
- I further authorize my Network to use my name where necessary in Patient Subject Matter meeting minutes and in listing in reports to the Centers for Medicare & Medicaid Services (CMS) and other business documentation.

Applicant Signature _____ **DATE:** _____

Staff Signature (if Applicable): _____ **DATE:** _____

You may submit completed forms to Midwest Kidney Network by faxing to 651-644-9853 or mail it to 2901 Metro Drive, Suite 400, Bloomington, MN 55425.

If you have any questions, please contact us at 800-973-3773.