Midwest Kidney Network (ESRD Network 11)
1360 Energy Park Drive, Suite 200
Saint Paul, MN 55108
1(800) 973-3773 | (651) 644-9853 Fax
midwestkidneynetwork.org

Patient Subject Matter Expert Application Form

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

About You	
I am (check one):	____Patient____Family/Caregiver____Stakeholder
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	
Email Address	
I identify as:	____American Indian or Alaska Native ____Asian ____Black/African American ____Native Hawaiian or Other Pacific Islander ____White ____Other
Ethnicity: I identify myself as	____Hispanic/Latino_____Not Hispanic or Latino
I mainly speak:	____English ___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)	____In-Center Hemodialysis: M/W/F or T/T/S ____Peritoneal Dialysis ☐ Home Hemodialysis ____Transplant, if yes, number of years as a transplant recipient_____
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
Connecting With You	
Preferred Method of Contact	☐ Phone ☐ Email ☐ Mail

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 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 form to Network 11 by fax to 651-644-9853 or mail it to 1360 Energy Park Dr, Suite 200, St Paul, MN 55108.
If you have any questions, please contact us at 800-973-3773

(Note: If we receive more applications than there are available slots, we may refer to your application at a later date, if additional SME participants are needed.)