



The Renal Network Patient Leadership Committee

OVERVIEW

The Patient Leadership Committee (PLC) is a dynamic group of patients and professionals that help the Network respond to patient needs and seek ways to improve patient/staff relationships. The PLC represents a cross section of patient treatment modalities from across the Network. This committee provides an approach to patient-related issues and concerns that involve continuously seeking better ways to do things --- ways that lead to more informed patients and better treatment results. This committee acts as an advisory group to the Network's Patient Services Department.

GOALS

- Develop informational and educational resources related to renal disease
- Identify and address needs and concerns of renal patients
- Provide information and feedback to the Patient Services Department

MEMBERSHIP on the PLC requires:

- A staggered three year term of office with the option of serving additional terms
- Attend three meetings a year; two unexcused absences within a year result in termination
- Ability to travel – meetings are held in different locations within the states of Illinois, Indiana, Kentucky, and Ohio (travel expenses are reimbursed)
- Experience with renal issues
- Willingness to work on educational projects and activities

CATEGORIES OF MEMBERSHIP

1. Patients (maximum 12), 18 years of age or older
2. Family members/caregivers (maximum 3)
3. Professionals (maximum 8)
4. Members at large (maximum 2)



NOMINATION FORM PATIENT LEADERSHIP COMMITTEE

Term of Office: January 1, 2010 – December 31, 2012

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Renal Facility
Affiliation: _____

Facility Address: _____

Facility Phone: _____ Facility Fax: _____

Are You A:	<input type="checkbox"/> Patient:	<input type="checkbox"/> Incenter Dialysis	<input type="checkbox"/> Peritoneal Dialysis
		<input type="checkbox"/> Home Hemodialysis	<input type="checkbox"/> Transplant
	<input type="checkbox"/> Family Member:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling
		<input type="checkbox"/> Spouse	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Staff:	<input type="checkbox"/> Administrator	<input type="checkbox"/> Social Worker
	<input type="checkbox"/> Physician	<input type="checkbox"/> Dietitian	
	<input type="checkbox"/> Nurse	<input type="checkbox"/> Technician	
<input type="checkbox"/> Other:	_____		

What Are The Reasons You Would Like To Serve On This Committee? (Use Back, If Needed)

Please Include The Name And Phone Number Of One Reference, Preferably A Kidney Staff Member:

Name: _____ Phone: _____

Relationship: _____

Send completed application form to: The Renal Network, Inc., 911 East 86th Street, Suite 202, Indianapolis, IN 46240-1858 or Fax: 317-257-8291. Attn: Patient Services.