



# NOMINATION FORM PATIENT LEADERSHIP COMMITTEE

Term of Office: January 1, 2008 – December 31, 2010

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 86<sup>th</sup> Street, Suite 202, Indianapolis, IN 46240-1858 or Fax: 317-257-8291. Attn: Patient Services.