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Patient Advisory Committee Nomination Form

Your name (Printed) _____ Phone/email _____

Signature _____

Name: _____

Current Position: _____

Home/Facility/Practice Name: _____

Home/Facility/Practice Mailing Address: _____

Phone: _____

Fax: _____ E-Mail: _____

Current & Previous Modality(ies): _____ Years at this Modality: _____

Other Renal Org. Affiliation(s): _____

Previous Heartland Kidney Network Board/Committee Experience: _____

Previous ESRD volunteer experience _____

Are you able to travel to Kansas City, Missouri for meetings? _____

Short background/biographical information: _____

What else should voters know about the candidate?

What goals and objectives would you like to see the Heartland Kidney Network's PAC achieve in the next two years? As a member of the Committee how would you assist in accomplishing those goals? Are there any specific areas of care that you would like to see the Board develop evaluation programs for or monitor?

Why are you interested in participating on the PAC? What are your goals and interests for joining?

Signature or letter of recommendation from a dialysis professional (optional)

I have read the attached PAC expectations, responsibilities and goals and agree to be nominated to the PAC.

Signature: _____

Return the completed Nomination form(s) to:

Attn: Patient Advisory Committee
Heartland Kidney Network
7306 NW Tiffany Springs Pkwy, #230
Kansas City, MO 64153
Fax (816) 880 9088

If you have any questions, contact Anne Karanja, MPH, Patient Services Coordinator
(800) 444-9965.