



Improving Healthcare
for the Common Good

End-Stage Renal Disease Network of New York
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CERTIFIED

Patient Advisory Committee Representatives

Unit Name: _____ Provider Number: 33- _____

Address: _____

Please fax completed form to the Network @ 516-326-8929

Please print clearly.

Name(s) of Social Worker(s): _____

Contact Phone Number(s): _____

Add OR Delete

Name of PAC representative: _____

Address: _____

Phone Number(s): _____

Day/Shift: _____

E-mail: _____

Add OR Delete

Name of PAC representative: _____

Address: _____

Phone Number(s): _____

Day/Shift: _____

E-mail: _____

Please make copies of this blank form for future use and keep the Network posted of changes with your PAC representatives including telephone numbers, email and home addresses.