The Renal Network
ESRD Networks 9 & 10

Network Patient Representative Program

Network Patient Representative Program (NPRP)
Participation Form

Facility name: _____ **CCN (provider) #** _____

Facility address: _____

city state zip

Facility phone:_____ **Facility e-mail:** _____

Patient Representative:

Name: **(please print)** _____

last first middle initial

Home Address: _____

city state zip

Current modality: _____ Years as a kidney patient: _____

Primary Phone: _____ E-mail: _____

Are you currently on the kidney transplant list? Yes ☐ No ☐

Signature _____

(over)

Designated Facility Staff Coordinator

Name: _____
last first middle initial

Position: _____

Primary Phone: _____ E-mail: _____

Once this form is completed, please return it to The Renal Network:
FAX to 317-257-2120, attention Katie Stark.
E-mail it to: KStark@nw10.esrd.net
Or mail it to: The Renal Network
911 East 86th Street, Suite 202
Indianapolis, IN. 46240

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