HSAG HEALTH SERVICES ADVISORY GROUP
ESRD Network 17

2020 Facility Patient Representative (FPR) Participation Agreement Form

All fields must be completed by staff. Participation Agreement to be signed by FPR.
Fax to 415.897.2422. Please do not email forms to the Network.

Facility Medicare Provider/CCN*		
Facility Name:		
Facility Address:		
Quality Improvement Activity (QIA) Assignment(s): *(if applicable)*	☐ Home Dialysis ☐ Transplant ☐ Support Gainful Employment	☐ Bloodstream Infection (BSI) ☐ BSI/Long-term Catheter (LTC)
QIA Staff Lead Information:	Full Name: Title: Phone Number: Email:	
FPR Full Name:		
FPR CROWNWeb UPI* Number:		
FPR Mailing Address:		
FPR Phone Number:	Home: Cell:	FPR Email Address: (***Required***)
Number of Years as a Dialysis Patient: Number of Years Transplanted:		
FPR Dialysis Schedule: *(Please check days)*	☐M ☐T ☐W ☐Th ☐F ☐Sat ☐Sun	
Patient Current Treatment Type (*Please check type.*)	☐ In-Center Hemodialysis (ICHD) ☐ ICHD Nocturnal ☐ Home Hemodialysis	☐ Peritoneal Dialysis ☐ Transplant
Is the patient currently on a transplant waitlist?	☐ Yes ☐ No ☐ N/A	
Additional Notes:		

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Participation Agreement

I_____(print name) agree to participate as a Facility Patient Representative (FPR) for Network 17. I give my permission for Network 17 and it partners to take photos and videos of me and my property, use my image in print or electronic form for any lawful reason, with or without my name. I have the right to submit a written request to cancel my approval at any time for any reason (except for materials that have already used my image), refuse signature of this form (without consequence), and receive a copy of this form. I understand that my image may be used in publicity, marketing, and web content. My approval will not affect any service Network 17 may provide me, and my approval will last 20 years from the day I sign this agreement. Network 17 will not be able to protect my image once it is public, and I will not be paid for allowing Network 17 to use my image.

I have read and understand the above:

FPR Printed Name		**Date**	
FPR Signature			

Reminder: Do not submit this form through email.
Fax: 415.897.2422

*CCN = CMS Certification Number
CMS = The Centers for Medicare & Medicaid Services
UPI = Unique Patient Identifier