Arkansas Department of Health
Division for Health Protection (DHP)
4815 West Markham, Slot #35
Little Rock, AR 72205
Phone: (501) 686-2807
Fax: (501) 686-2381

Kidney Disease Advisory Council (KDAC)

Application for Council Membership Appointment

Applicants for appointments must complete this form and submit it to the DHP-Personal Care Services Branch. Failure to complete all parts of the application will delay the review and processing of your application.

Requirements:

The seven members of the Arkansas Kidney Disease Advisory Council are appointed by the Arkansas State Board of Health to serve a tenure of four (4) years, to expire on January 14 of the members' fourth year of the appointed term. Members shall serve until their successors are appointed and qualified.

Representation is set by Arkansas law under Act 852 of 2025 and includes:

I. Three (3) members who are knowledgeable in renal medicine and the treatment of end-stage renal disease.
   (a) Shall be physicians licensed to practice in Arkansas.
   (b) Are actively engaged in the private practice of medicine in this state.

II. One (1) member who is knowledgeable in renal medicine and the treatment of end-stage renal disease.
   (a) shall be a physician licensed in Arkansas.
   (b) is engaged primarily in the institutional practice of medicine.

III. One (1) member shall be engaged in hospital administrative activities.

IV. One (1) member shall be named from the public at large.
   (a) He or she shall have demonstrated interest in the treatment and cure of renal diseases.
   (b) May be a representative from an Arkansas-based nonprofit organization dedicated to the treatment and cure of renal diseases.

V. One (1) member who shall represent the elderly.
   (a) shall be sixty (60) years of age or older
   (b) Shall be appointed from the state at large.
   (c) Shall not be actively engaged in or retired from any profession, occupation, or industry which is regulated pursuant to this A.C.A. § 20-15-601, *et seq.*

If you are interested in being considered for membership on the Advisory Council and meet one or more of the requirements above, please complete this application along with **any supporting documents** and e-mail to Charles Bedell, Branch Chief, Personal Care Services, Arkansas Department of Health at charles.bedell@arkansas.gov .

Personal Information ***Please Type or Print Legibly***

Name (First, Middle, Last)			
Date of Birth (*MM/DD/YYYY*)	Email Address		
Cell Phone	Work Phone or Alternate Phone		
Physical Address			Suite/Apt._____
City	State	Zip	County
Mailing address (**if different from physical address**):			
City	State	Zip	County

Advisory Council member representation (**Please check the box next to the option you are seeking membership under**.):

[ ] Renal medicine-private practice. **[ ]** Renal medicine-institutional practice. **[ ]** Hospital administration.

[ ] A representative from the public at large. **[ ]** Elderly/retiree (60 years of age or older).

Employment Background (attach additional sheets if necessary)

Employer Name			Start Date	End Date
Address	Suite/Apt		Phone Number	Years Employed
City	State	Zip		County
Supervisor's Name				

Employer Name			Start Date	End Date
Address	Suite/Apt		Phone Number	Years Employed
City	State	Zip		County
Supervisor's Name				

Please write a brief description of why you would be a strong candidate to be appointed to this Advisory Council, and any additional information you feel would be relevant for the membership category for which you are applying.

Attestation:
I, the undersigned, attest that:

- I am currently not, nor have I been a registered lobbyist.
- I am currently not under charges for violation of law or involved in litigation.
- I have never been convicted of a crime other than minor traffic violations.

The information provided in this application is accurate to the best of my knowledge, and that I am committed through this Advisory Council to actively contributing to the Kidney Disease Program's goal of assisting persons suffering from acute or chronic renal failure in obtaining care and treatment.

Signature: _____ Date: _____