Advisory Committee Candidate Information Form

Name: _____ **Position:** _____

Organization: _____

BUSINESS Address: _____

_____

Phone: _____ **Fax:** _____ **Email:** _____

HOME Address: _____

_____

Phone: _____ **Fax:** _____ **Email:** _____

Gender: □ Male □ Female

Date of Birth: _____

Place of Birth: City _____ State _____

Race/Ethnicity:
□ African American/Black
□ Asian
□ Hawaiian/Pacific Islander
□ Hispanic/Latino
□ Native American/Alaskan Native
□ White/Non-Hispanic
□ Other (specify) _____

Program/Discipline Represented:
□ AHEC
□ Allied Health
□ Chiropractic
□ Geriatrics Related Program
Specify_____
□ Graduate Psychology
□ HETC
□ Rural Health
□ Advanced Nursing Practice
□ Social Work
□ Podiatry
□ Physician Assistant
□ Physicians Only (Indicate Allopathic or Osteopathic)
Family Medicine ____ General Pediatrics ___ General Internal Medicine
□ Dentistry: General ____ Pediatric ____ Dental Hygiene ____

Program Experience:
□ Health Professional Engaged in Community-Based Interdisciplinary Training
□ Health Professional from Public or Private Teaching Hospital
□ Leader of a Health Profession Organization
□ Faculty Member of an Academic Institution
□ Student/Intern/Resident/Fellow Should Specify Program Affiliation
□ Program Evaluation Expertise
□ Health Insurers, Business, Labor

Geographic Area Represented: State: _____ □ Urban □ Rural

CV Attached: □ Yes □ No, will submit by: _____

Personal Statement of Interest Attached: □ Yes □ No, will submit by: _____

Prior Membership on DHHS Committees: □ No □ Yes (provide name/terms) _____