Board of Directors Application

FEDERAL DOCUMENTATION

The information below is requested to ensure that the Board maintains the composition required by the Bureau of Primary Health Care.

Are you currently a client, or the parent of a client, of Celebrating Life Community Health Center? (You and/or your child has been seen by a provider within the last 24-months.)

YES NO

Monthly Board of Directors Meetings occur at Celebrating Life Community Health Center, 27271 Las Ramblas, Suite 350, Mission Viejo, CA 92691 (or via telephone or teleconference). Meetings are generally scheduled for the last Thursday of each month at 6:00 p.m. Will you be able to attend monthly meetings?

YES NO

Date of Birth (month/day/year):____/___/_____

Gender

FEMALE MALE

Race

Asian	Native Hawaiian
American Indian/Alaska	Other Pacific Islander
Native	White
Black/African American	More than one race

Ethnicity

Hispanic or Latino Non-Latino

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PERSONAL INFORMATION

Name
Last:_____First:_____Middle:____

Home Address: _____

Phone
Home: _____ Work: _____ Cell: _____

Email Address: _____

WORK HISTORY

Are you currently employed in the health care industry?

YES NO

Please provide information about your present employment. Retired individuals, or those presently unemployed, may provide most recent employment information. Please attach your complete professional CV or resume separately.

Employer:_____

Job Title: _____

Dates of Employment (month/year):_____to_____

Brief description of work responsibilities: (up to 75 words)

_____

_____

EDUCATION AND TRAINING

Education: High School (or equivalent) -or- College/University

Degrees (degree, college/university):
Undergraduate: _____

Graduate: _____

Additional Training, Certification: _____

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STATEMENT OF INTEREST

Why are you interested in the health of our community? (up to 150 words):

_____

_____

_____

_____

Please enter your full name in the areas marked "Print Name" and "Signature." By completing hand-written or electronic signatures, you identify yourself as the person completing this application and acknowledge Release of Information Consent and Consent to Photograph.

RELEASE OF INFORMATION CONSENT

The information I have provided and the responses given are correct and complete to the best of my knowledge and belief. Celebrating Life Community Health Center staff or board members may contact any individuals/agencies, etc., documented in this application for the purpose of verifying the information provided. Additionally, I am aware that my application is subject to public disclosure.

_____ _____ _____

Print Name Signature Date

CONSENT to PHOTOGRAPH

I authorize Celebrating Life Community Health Center to videotape, take a digital image or other image of me, and I agree that the negatives, digital images, video, or photographs may be kept, stored, and used in health center promotion and publications.

_____ _____ _____

Print Name Signature Date

Health Center Use:

Application received by _____ _____

Date

Application CV/resume additional attachments _____