
APPLICATION FOR ADVISORY BOARD MEMBERSHIP

NAME: LAST _____ **FIRST** _____ **M.I.** _____

HOME ADDRESS: _____

HOME TELEPHONE: _____ **CELL PHONE:** _____

EMPLOYER: _____

BUSINESS ADDRESS: _____

BUSINESS TELEPHONE: _____ **E-MAIL:** _____

*** OCCUPATION & TITLE:** _____

*** RACE: CAUCASIAN**__ **AFRICAN-AMERICAN**__ **HISPANIC**__ **OTHER (specify)**_____

- 1. How did you learn about the FCBHA Advisory Board?**
- 2. What are your reasons for requesting membership on the Advisory Board?**
- 3. Have you had any previous experience with community advisory groups, intellectual disability or mental health agencies or organizations, drug and/or alcohol programs, or service organizations. If so, please list:**
- 4. Please identify skills, education, and/or training you believe will assist you as a Board Member?**

** Denotes data that is requested to assure that the Demographics of the FCBHA Advisory Board are reflective of the demographics of Fayette County and Mental Health/Mental Retardation Act of 1966.*



5. How do you feel you can contribute to the Advisory Board?

_____ Yes _____ No

If yes, please list and provide dates of terms served:

7. Are you currently an elected official?

_____ Yes _____ No

If yes, list capacity:

8. Have you been, or are you currently employed at any county office or provider of service agencies?

_____ Yes _____ No

If yes, please denote office and employment dates:

9. The Advisory Board meets six times per year in the evening on the third Wednesday of the month. Can you make a commitment to attend the meetings as scheduled?

_____ Yes _____ No

10. References: (Please list three)

| Name | Position/Title | Address | Telephone # |
|------|----------------|---------|-------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Applicant Signature

Date