



Board of Directors Application

Date of Application: _____

Are you currently a client of the Nature Coast Community Health Center (i.e. you have been seen by a provider within the last 12 months?) Yes No

PERSONAL INFORMATION

Name: Last: _____ First: _____ Middle: _____
Home Address: _____ _____
Phone: Home: _____ Work: _____ Cell: _____
E-Mail: _____

WORK HISTORY

Are you currently employed in the health care industry? Yes No

Please provide a brief work history from most recent.

Employer: _____

Job Title: _____

Dates of Employment: _____

Brief description of responsibilities:

Employer: _____

Job Title: _____

Dates of Employment: _____

Brief description of responsibilities:

Employer: _____

Job Title: _____

Dates of Employment: _____

Brief description of responsibilities:

ADDITIONAL QUALIFICATIONS/TRAINING

Education: _____

- High School or equivalent
- College
- Other (specify: _____)

Please provide information about any relevant training you have had. If more space is needed, please include an attachment.

Training Name	Training Date	Brief Explanation (if not self-explanatory)

Why are you interested in becoming a board member?

Why are you interested in the health of our community?

What do you hope to accomplish as a board member?

REFERENCES

Please list three (3) who do not include relatives.

Reference 1:
Name:
Address: City, State, Zip: Telephone:
Relationship:

Reference 2
Name:
Address: City, State, Zip: Telephone:
Relationship:

Reference 3
Name:
Address: City, State, Zip: Telephone:
Relationship:

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

Date of Birth: _____

Female Male

Race:

Asian Native Hawaiian Other Pacific Islander Black/African American

American Indian/Alaska Native White More than one race

Ethnicity:

Hispanic or Latino Non-Latino

RELEASE FORM

All of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. You may contact any individuals/agencies, etc that I have documented in this application.

Signature

Print Name: _____

Date: _____

CONSENT TO PHOTOGRAPH

I authorize the Nature Coast Community Health Center and the DOH Hernando County Health Department to photograph, video, 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 its publications.

Signature

Print Name: _____

Date

Mail or deliver the completed application to:

NCCHC
300 South Main Street
Brooksville, FL 34601

Attention: Gina Dowler