



ADVISORY COUNCIL APPLICATION

APPLICATION FOR WHICH SEAT:

- CSL Representative
- Consumer of VCAAA Services (indicate which service used: _____)
- Service Provider – Health Care
- Focused Population – Behavioral Health

APPLICANT _____

ADDRESS: _____ PHONE: _____
_____ FAX: _____

1. Applicant is: (a) under 60 years of age (b) over 60
2. Occupation/Title _____
3. Your Employer _____
4. Your Email Address: _____

- | | | |
|---|--------------------------|--------------------------|
| 5. Applicant: | <u>Yes</u> | <u>No</u> |
| (a) is a member of a minority race | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) is <u>able</u> and <u>willing</u> to attend and participate in regular Advisory Council and Committee meetings. | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) is capable of communicating opinions as a representative of the community you are applying to represent. | <input type="checkbox"/> | <input type="checkbox"/> |

6. Summarize your qualifications for appointment (i.e. education, training, employment, experiences, licenses, etc):

7. Please briefly describe why you wish to serve on the Advisory Council:

8. Community Involvement/Activities:

9. Special Interests:

10. **Applicant's Declaration and Signature**

I certify under penalty of perjury under the laws of the State of California that all the information on this form is true and correct.

Signature

Date