TIDELANDS HEALTH

Community Partner Council application

Please print:

Name _____ _____ _____
(last) (first) (MI)

Address _____

City, state, zip code _____

Preferred phone number ( ) _____

Email address _____

Emergency contact _____ Phone ( ) _____

Language(s) you speak _____

Please answer the following:

1. Will you allow your contact information to be shared with other council members? ❑ yes ❑ no

2. Please check all that apply to your council membership:
   ❑ a patient ❑ family member of a patient ❑ community member

3. What is your interest in serving as a Tidelands Health Community Partner Council member?

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_____

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4. If you have served as an adviser, been an active volunteer or publicly represented other programs or organizations, please briefly describe your experience.

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