APPLICATION

SHASTA COUNTY MENTAL HEALTH, ALCOHOL AND DRUG ADVISORY BOARD

NAME _____ **PHONE (Hm)** _____

ADDRESS _____ **(Wk)** _____

_____ **(Cell)** _____

E-MAIL ADDRESS _____ **(Fax)** _____

AREA OF INTEREST:

REASON FOR APPLYING:

PRIOR EXPERIENCE RELATED TO MENTAL HEALTH, ALCOHOL AND/OR DRUG SERVICES:

MHADAB Members may not be employees of Shasta County HHSA or a company contracted with HHSA.

PLEASE LIST YOUR CURRENT EMPLOYER:

REFERENCES:

Name _____ **Phone:** _____

Address _____

Name _____ **Phone:** _____

Address _____

_____ _____

Signature **Date**

Please return this form to: Jacquelynnn Rose, HHSA BHSS Services Email: MHADAB@co.shasta.ca.us

2640 Breslauer Way, Redding, CA 96001. Phone: (530) 229-8266

Office Use Only:

Date Received: _____

Submit form by E-Mail