APPLICATION FOR MEMBERSHIP ON THE
SHASTA COUNTY PUBLIC HEALTH ADVISORY BOARD

Name: _____ **Date of Application:** _____

Address: _____

Telephone Number(s): _____ **E-mail Address:** _____

Agency/Organization You Are Affiliated with, if any_____

Represent the following geographic area of Shasta County: _____

Check all that apply:

- ☐ Board of Supervisor District Representative
- ☐ Health Clinic/Hospital/Medical Service Agency
- ☐ Health Practitioner
- ☐ Community Based Organization
- ☐ School, School District, County Office of Education
- ☐ Environmental Health Agency
- ☐ Faith Community
- ☐ Partnership for the Public's Health or other group partnering in Public Health activities
- ☐ Other Government (City, State, Other County Dept. or Official)
- ☐ Interested Citizen
- ☐ Public Health Client/Customer (or Parent/Guardian of)
- ☐ Senior Citizen or Senior Citizen Agency
- ☐ Community Health Coalition
- ☐ Advocate for the age zero to five population
- ☐ Business Community
- ☐ Ethnic Population
- ☐ Youth
- ☐ Other: _____

Complete the following. Attach additional pages, if necessary.

Give a brief description of your background related to public health and/or health services:

_____

_____

Give a brief description of your community service participation, now and in the past:

_____

What are your interests in or thoughts about Public Health?

_____

_____

Describe your vision of an effective public health department:

_____

_____

Describe your reason(s) for wanting to serve on the Shasta County Public Health Advisory Board:

_____

_____