Region II

Behavioral Health Board

**Candidate’s Application of Intent to Serve**

**NAME:** Click or tap here to enter text.

**HOME PHONE:** Click or tap here to enter text. **CELL PHONE:** Click or tap here to enter text.

**WORK PHONE:** Click or tap here to enter text. **EMAIL:** Click or tap here to enter text.

**HOME ADDRESS:** Click or tap here to enter text.

**CITY:** Click or tap here to enter text. **STATE:** Click or tap here to enter text. **ZIP CODE:** Click or tap here to enter text.

**USUAL DAILY ACTIVITY/OCCUPATION:** Click or tap here to enter text.

**IS YOUR NOMINATION ON BEHALF OF A COMMUNITY ORGANIZATION, BOARD, COMMISSION OR COUNCIL?**

**YES**  **NO**  **IF YES, PLEASE LIST:** Click or tap here to enter text.

**BASED UPON YOUR OWN SPECIAL INTERESTS AND SKILLS, IN WHAT WAYS ARE YOU INTERESTED IN CONTRIBUTING TO THE REGION II BEHAVIORAL HEALTH BOARD?**

Click or tap here to enter text.

**PLEASE COMMENT ON ANY KNOWLEDGE OR EXPERIENCE YOU HAVE IN THE FIELDS OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS. LIST ANY PREVIOUS EXPERIENCE WITH BOARDS, COUNCILS, ETC.**

Click or tap here to enter text.

**PLEASE ADD ANY INFORMATION THAT YOU THINK MIGHT BE RELEVANT TO YOUR APPOINTMENT.**

Click or tap here to enter text.

**ARE YOU ABLE TO ATTEND MONTHLY MEETINGS?** **YES**  **NO**

**(OUR NORMAL MEETING TIME IS THE 2ND THURSDAY OF EACH MONTH FROM 1:30PM - 3:30PM IN LEWISTON)**

**ARE YOU WILLING TO WORK ON COMMITTEE’S OR SPECIAL PROJECTS OTHER THAN ATTENDING THE MONTHLY MEETING? YES**  **NO**

**MY APPLICATION BEST FILLS THE FOLLOWING STATE REQUIRED CATEGORIES (check up to 3):**

**County Commissioner or their designee**

**Department of Health and Welfare employee**

**Parent of a child with a serious emotional disturbance**

**Parent of a child with a substance use disorder**

**Law enforcement officer**

**Adult mental health consumer representative**

**Mental health advocate**

**Substance use disorder advocate**

**Adult substance use disorder consumer representative**

**Family member of an adult mental health consumer**

**Family member of an adult substance use disorder consumer**

**Private provider of mental health services**

**Private provider of substance use disorder services**

**School district representative (elementary or secondary)**

**Juvenile justice system representative**

**Adult correction system representative**

**Judiciary representative (appointed by the administrative district judge)**

**Physician or other licensed health practitioner**

**Hospital representative**

**SUBMITTED BY:** Click or tap here to enter text. **DATE:** Click or tap here to enter text.

**Please Return This Application To:**

**Perri Larson plarson@phd2.idaho.gov**

**PUBLIC HEALTH – IDAHO NORTH CENTRAL DISTRICT**

**215 10TH STREET ⬝ LEWISTON, ID 83501**

**FAX: (208) 799-0349**