

REGION II

*Behavioral Health Board*

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

NAME: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

USUAL DAILY ACTIVITY/OCCUPATION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

YES NO IF YES, PLEASE LIST: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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.

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\_\_\_\_\_

\_\_\_\_\_

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

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\_\_\_\_\_

\_\_\_\_\_

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

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

Prevention specialist

\_\_\_\_\_  
SUBMITTED BY:

\_\_\_\_\_  
DATE

**Please Return This Application To:**

Perri Larson [plarson@phd2.idaho.gov](mailto:plarson@phd2.idaho.gov)  
PUBLIC HEALTH – IDAHO NORTH CENTRAL DISTRICT  
215 10<sup>TH</sup> STREET • LEWISTON, ID 83501  
FAX: (208) 799-0349