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.

_____

_____

_____

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

_____

_____

_____

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

APPLICANT SIGNATURE _____ DATE _____

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