OAK ORCHARD HEALTH
BOARD OF DIRECTORS MEMBER
APPLICATION (CONFIDENTIAL)

_____ _____
NAME Gender (M/F)

_____ _____
ADDRESS TELEPHONE

_____ _____
CITY STATE/ZIP EMAIL

_____ _____
NAME OF CURRENT EMPLOYER OCCUPATION

REFERRED TO: OAK ORCHARD HEALTH BY_____

_____

DO YOU DERIVE 10% OR MORE OF YOUR INCOME FROM THE HEALTHCARE INDUSTRY?
YES_____NO_____
IF YES, PLEASE NAME THE SOURCE_____

OAK ORCHARD HEALTH (OOH) IS REQUIRED TO HAVE A TRUE REPRESENTATION FOR THE COMMUNITIES IT SERVES, INCLUDING A MAJORITY OF THE BOARD MEMBERS BEING HEALTH CENTER USERS. MEMBERS SHOULD REPRESENT THEIR COMMUNITIES IN AGE, INCOME DISTRIBUTION, GENDER AND ETHNICITY. IN ADDITION, IT IS IMPORTANT TO HAVE PEOPLE EXPERIENCED IN COMMUNITY AFFAIRS, GOVERNMENT, BANKING/FINANCIAL, LEGAL, BUSINESS, AND SOCIAL SERVICES.

AREA OF EXPERTISE: _____
_____

WILL YOU BE ABLE TO ATTEND MONTHLY MEETINGS: YES_____NO_____
OOH CONDUCTS THEIR BOARD MEETINGS THE THIRD WEDNESDAY OF EACH MONTH. GENERALLY THE BOARD MEETING WILL BEGIN AT 6:00 PM AND LAST TWO HOURS.

IN ADDITION, YOU MAY BE ASKED TO BE A MEMBER OF ONE OR MORE OF THE OAK ORCHARD HEALTH'S STANDING COMMITTEES.

I AM INTERESTED IN SERVING ON THE OAK ORCHARD HEALTH BOARD OF DIRECTORS BECAUSE:
_____
_____
_____
_____
_____

HAVE YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY WORKED FOR OR SUPPLIED PRODUCTS OR SERVICES TO OAK ORCHARD HEALTH: YES_____NO_____
IF YES, PLEASE EXPLAIN_____
_____
_____
_____

ARE YOU A USER OF OAK ORCHARD HEALTH SERVICES: YES____NO____
IF YES, WHEN DID YOU LAST USE THESE SERVICES?_____

ANY ADDITIONAL COMMENTS:_____
_____

PLEASE SEND THIS COMPLETED APPLICATION TO:

OAK ORCHARD HEALTH
300 West Avenue
Brockport, NY 14420

ATTN: EXECUTIVE ASSISTANT

OR CALL (585) 637-4990 (extension 214) WITH ANY QUESTIONS.

_____
SIGNATURE

_____
DATE

Approved: 11-28-12