OAK ORCHARD HEALTH

APPLICATION FOR BOARD OF DIRECTORS MEMBERSHIP

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City & Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Did You Learn of the Opportunity to Serve on the OOH Board of Directors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # (Land) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If Retired, Indicate Former Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You or a Dependent Adult or Child Currently a Patient of OOH? \_\_\_\_Yes\_\_\_\_No

If Yes, Have You or Your Dependent Received Treatment in the Past Twenty-four (24) Months? \_\_\_Yes \_\_\_No

Do You or Any Member of Your Family Work For or Supply Goods and Services to OOH? \_\_\_Yes\_\_\_No

Below, Please Indicate Why You are Interested In Serving on the OOH Board of Directors, Indicating the Contributions You Believe You Can Make to OOH’s Mission:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Have Prior Experience As a Not-for-Profit Board Member? \_\_\_Yes \_\_\_No. If Yes, Please Identify the Organization and Your Role.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Currently Derive 10% or More of Your Income From the Health Care Industry? \_\_\_Yes \_\_\_No

If Yes, Please Identify the Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will You Be Able to Attend Monthly Board Meetings (Held the Third Wednesday of Each Month)? \_\_\_Yes \_\_\_No

Are You Willing to Complete (At No Personal Financial Cost) the On-line Board Member Training Program Provided by the National Association of Community Health Centers (NACHC) Within the First Six (6) Months of Appointment to the Board? \_\_\_Yes \_\_\_No

As an agency supported in large part by government funds, Board members are required to be vetted. If asked to join the board, are you willing to provide your Social Security number and Date of Birth? \_\_\_\_Yes \_\_\_\_No

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rec’d\_\_\_

IF AVAILABLE, PLEASE ATTACH A COPY OF YOUR MOST RECENT PROFESSIONAL/PERSONAL RESUME’ AND FORWARD THE COMPLETED APPLICATION TO: EXECUTIVE ASSISTANT, OAK ORCHARD HEALTH, 300 WEST AVE., BROCKPORT NY 14420. IF QUESTIONS, CALL 585-637-4990, EXT. 214