



OAK ORCHARD COMMUNITY HEALTH CENTER (OOHC)
APPLICATION FOR BOARD OF DIRECTORS MEMBERSHIP

Name: _____

Address: _____ City & Zip: _____

Phone # (Land): _____ (Cell) _____ E-mail: _____

Occupation: _____ Address including Zip Code: _____

If retired, indicate former occupation: _____

How did you learn of the opportunity to serve on the OOH Board of Directors? Referral by staff? Board member? Patient? Non-patient friend or associate? Our website? Bulletin board at one of our sites, if so, which? This can have more than one response _____

Oak Orchard Health Center's mission is to cultivate patient-centered health and wellness by providing engaged and innovative health care for our community. OOHC is a Federally Qualified Health Care Center (FQHC): a community-based and patient-centered health care center providing our services to EVERYONE, regardless of insurance status or ability to pay. Our core values are excellence, respect, and integrity.

Below, please tell us why you are interested in serving on the OOH Board of Directors, indicating the contributions you believe you can make to OOH's mission.

Please tell us about your community connections with social services organizations, advocacy or health care.

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 have knowledge, skills and/or expertise in:

Finances or analytics? ____ Risk management or compliance? ____ Human Resources? ____

Strategic planning or quality improvement? _____ Communications or marketing? _____ Healthcare? _____

Do you have any professional certifications? _____

Have you represented, worked closely with, or do you have expertise in, the Farmworker MSFW/MSAW Community?

Will you be able to attend board meetings held on the 4th Wednesday of each month (in person or virtual)?
____ Yes ____ No

Will you be able to participate in committees as needed? This may be in person or virtual. ____ Yes ____ No

Have you been an OOCHC Patient in the last 24 months? Medical, dental, vision or behavioral health (do not need to specify) ____ Yes ____ No

Do you have a dependent adult or child that has been an OOCHC Patient in the last 24 months? ____ Yes ____ No

Do you have the legal authority to make health care decisions for a patient? ____ Yes ____ No

If you are NOT a patient, do you derive more than 10% of your income from the health care industry (to include persons with direct patient contact including medical, dental, and behavioral health providers, nurses, and those in direct support roles such as medical assistant or technician, and patient-facing staff of a hospital or outpatient facility)? If so, please explain: _____

Do you or any member of your family work for or supply goods or services to OOH? ____ Yes ____ No

Are you willing to complete (at no personal financial cost) the online 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 federal 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* _____

Please attach: A copy of your most recent professional or personal resume or CV to:

Michael Kozlowski
Governance Committee Chair

If you have any questions, please email Michael Kozlowski at Governance.Committee@oochc.org