

## Member Agreement Penquis District Coordinating Council

I, \_\_\_\_\_, wish to serve on the Penquis District Coordinating Council. I am aware of my membership responsibilities as described in the Governance Document.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Please check the organizational categories with which you have an affiliation (check all that are applicable):

- |  |   |
|--|---|
| <input type="checkbox"/> County Government               | <input type="checkbox"/> Clinic/Community Health Center     |
| <input type="checkbox"/> Municipal Government            | <input type="checkbox"/> Voluntary Health Organization      |
| <input type="checkbox"/> City Health Department          | <input type="checkbox"/> Family Planning Organization       |
| <input type="checkbox"/> Hospital                        | <input type="checkbox"/> Area Agency on Aging               |
| <input type="checkbox"/> Emergency Management Agency     | <input type="checkbox"/> Adult Mental Health Services       |
| <input type="checkbox"/> Emergency Medical Services      | <input type="checkbox"/> Adolescent Mental Health Svcs.     |
| <input type="checkbox"/> Tribes                          | <input type="checkbox"/> Cognitive or Physical Disabilities |
| <input type="checkbox"/> Healthy Maine Partnership       | <input type="checkbox"/> Substance Abuse Services           |
| <input type="checkbox"/> School District                 | <input type="checkbox"/> Worksite Wellness                  |
| <input type="checkbox"/> Local Health Officer            | <input type="checkbox"/> Community-Based Org.               |
| <input type="checkbox"/> Institution of Higher Education | <input type="checkbox"/> Issue-Specific Coalition           |
| <input type="checkbox"/> Health Care Provider            | <input type="checkbox"/> Maine CDC/DHHS                     |

The following populations are affected by health disparities. Please check those for which you could provide either content knowledge or representation:

- |   |  |
|---|--|
| <input type="checkbox"/> Age            | <input type="checkbox"/> Rural/Urban           |
| <input type="checkbox"/> Disability     | <input type="checkbox"/> Sexual Minority       |
| <input type="checkbox"/> Gender         | <input type="checkbox"/> Socio-economic status |
| <input type="checkbox"/> Race/Ethnicity | <input type="checkbox"/> Veteran's status      |

If applicable, please check the following:

- I would like to serve on the Membership Committee
- I would like to serve on the District Health Improvement Planning Committee
- I would like to serve on the Governance Committee
- I would like to serve on the Executive Steering Committee

(over, please)

**Contact Information**

Organization:

Title or role:

Mailing address:

City, State, Zip:

Email (please write clearly):

Telephone (best to use):