1. Name:

First Middle Last

1. Address (including Zip Code):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Phone number: (     )      \_\_\_\_\_

E-mail address:

4. Gender:  Male  Female

5. Ethnicity (optional):

American Indian or Alaskan Native  Asian  Black

Hispanic  Pacific Islander  White

Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Nomination by:

Self  Organization/Association:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Application Category: Please select the category or categories for which you are applying.

*Currently, we are accepting applicants for these categories:*

Service Provider Representative

Family Member Representative

Please provide a brief statement of qualifications that highlights the relevant skills and experience you would bring to the Alzheimer’s Advisory Committee.

In addition, please answer these questions:

1. Briefly describe the interests you will represent and what you hope to contribute as a result of participating on the Alzheimer’s Advisory Committee.
2. What are the central Alzheimer’s issues you would recommend the committee consider and why?

SIGNATURE DATE

Signature of a personal assistant is acceptable.

Please submit application either by email or by mail.

By Email: frances.parker@chhs.ca.gov, OR

By Mail:

California Health and Human Services Agency

1600 9th Street, Room 460

Sacramento, CA 95814

Attn: Frances Parker