CHOICE
Community Health Organization
Improving Care and Equity

BOARD MEMBER APPLICATION FORM

Instructions

Please complete the application form if you are interested in becoming a member of CHOICE Regional Health Network. Your application will be reviewed by the CHOICE Governance Committee at their next regular meeting.

Personal Information

Name	
Street Address	
City	
State	Zip
Organization Affiliation	
What counties and/or Tribal Nations does your live in?	
What counties and/or Tribal Nations does your organization serve?	
Have you been referred by a current CHOICE Board Director? If so, whom?	

What best describes your organization?

- ○ Tribal
- ○ Community Health Care Center
- ○ Medical Groups or Health Care
- ○ Hospital Social
- ○ Service Provider
- ○ Provider Network
- ○ Public Health
- ○ Behavioral Health Provider
- ○ Education
- ○ Other:

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Please provide a brief statement why you would like to become a member of CHOICE Regional Health Network?
How does your work or your organization plan to contribute to the achievement of the CHOICE mission?

Signature	Date

Send competed application to eckhartd@crhn.org. If you have any questions, please call (360) 539-7576.

Please include the following materials along with this completed application:

1. Your resume/CV is available.
2. Your organization's annual report, if applicable.
3. Your organization's strategic initiatives, if applicable.