**DEPARTMENT OF HEALTH**
**Health Systems Quality Assurance Division**
**Office of Community Health Systems**

# *Regional EMS and Trauma Care Council*
# MEMBERSHIP APPLICATION

Please print all information and complete both sides of this application.

**1.** I, _____ am applying for appointment ☐ / reappointment ☐
*(Check One Above)*

as the _____ representative on the
*(please specify if "alternate")*

_____ Region EMS/Trauma Care Council from _____ County.

**2.** Preferred mailing address for Regional Council business:

_____

_____

_____

Contact information:

Work (_____)_____ Home (_____)_____

FAX (_____)_____ Email:_____

**3.** **LOCAL EMS COUNCIL RECOMMENDATION:**

Chair / President: _____

Signature: _____ Date _____

**4.** Complete if you are formally representing an agency or organization:
*(attach any letters of recommendation)*

Agency / organization name: _____

Head of organization: _____

**5**. Please answer the following:

a) Why are you interested in serving on the Regional Council?

b) What are your abilities, i.e., education, employment and/or experience that qualify you for this position? (attach any additional information)

c) Current employment: _____

_____ _____

Applicant Signature Date

**Reset Form** **Print to Mail**

**Return completed form to:**

Mary Roberts
Regional Council Appointments Coordinator
Office of EMS and Trauma System
PO Box 47853
Olympia, WA 98504-7853

**Questions?** Call (360) 236-2804.

Personal Information (Optional):

*NOTE: The Governor and the Department of Health desire a broad representation of backgrounds on boards, committees and councils. The information below will assist in this goal and is voluntary on your part.*

Of what race or ethnicity do you consider yourself to be?

❑ Black/African-American
❑ Asian or Pacific Islander American

*If you are Asian or Pacific Islander, please check one box below:*

❑ Chinese ❑ Vietnamese
❑ Filipino ❑ Asian Indian
❑ Hawaiian ❑ Japanese
❑ Korean ❑ Cambodian
❑ Samoan ❑ Laotian
❑ Guamanian ❑ Other: _____

❑ White/Caucasian
❑ American Indian or Alaska Native

*If you are American Indian or Alaska Native, please check one box below:*

❑ Eskimo
❑ Aleut

*Enrolled or principal tribe if American Indian:*
Tribe: _____

❑ Latino(a), Hispanic, or Spanish?

*If you are Latino(a), Hispanic, or Spanish, please check one box below:*

❑ Mexican, Mexican-American, Chicano
❑ Puerto Rican
❑ Cuban
❑ Other Latino(a), Hispanic, or Spanish

*Enter group, such as Colombian, Dominican, etc.*
Group: _____

❑ Other Race: _____ Birth Date: _____/_____/_____ ❑ Female ❑ Male

Do you have a permanent physical, sensory, or mental condition that substantially limits your major life functions, such as working, caring for yourself, walking, doing things with your hands, seeing, hearing, speaking, and learning? ❑ Yes ❑ No

Have you ever been on active duty in the U.S. Armed Forces? ❑ Yes ❑ No