

HEALTH CARE FOR THE HOMELESS CLINICIANS' NETWORK
2008 STEERING COMMITTEE NOMINATION FORM

APPLICATION CHECKLIST: <input type="checkbox"/> This Nomination Form <input type="checkbox"/> Letter of approval from supervisor <input type="checkbox"/> Letter of interest in position <input type="checkbox"/> Current resume or c.v. <input type="checkbox"/> Current Network member

ELIGIBILITY REQUIREMENTS: Candidates must be current members of the HCH Clinicians' Network who have been a member for at least one year. Candidates must be clinicians who provide hands-on care in a Health Care for the Homeless (HCH) project funded through the Bureau of Primary Health Care or in a Projects for Assistance in Transition from Homelessness (PATH) program funded by the Center for Mental Health Services' Homeless Programs Branch. (check one) <input type="checkbox"/> HCH Project <input type="checkbox"/> PATH Program

Person Nominated: _____

Degree(s) & Title: _____

Organization Name: _____

Mailing Address: _____

City/State/ZIP: _____

Phone/FAX: _____

E-mail Address: _____

Candidate's Race/Ethnicity: (check one)		
<input type="checkbox"/> Asian or Pacific Islander	<input type="checkbox"/> African-American	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> White (non-Hispanic)	<input type="checkbox"/> Mixed or Other
Candidate's Gender: (check one)		
<input type="checkbox"/> Female	<input type="checkbox"/> Male	

Nominated by: _____

Address: _____

City/State/ZIP: _____

Phone: _____

NETWORK STAFF USE ONLY			
<input type="checkbox"/> Application complete	<input type="checkbox"/> Current member	<input type="checkbox"/> Region _____	<input type="checkbox"/> Grantee

<p>Application Deadline: March 31, 2008 Mail application to: Ms. Pat Petty HCH Clinicians' Network P. O. Box 60427 Nashville, TN 37206-0427 FAX: 615 226-1656 Questions? Call 505 872-1151</p>
