Tillamook County Community Health Centers
Administrative Office

503-842-3900 | 800-528-2938
TTY: 800-735-2900
Fax: 503-842-6099
tillamookchc.org
2204 4th Street | PO Box 489 | Tillamook, OR 97141

COMMUNITY HEALTH COUNCIL MEMBER APPLICATION FORM

CONTACT INFORMATION

Name _____

Address _____

City _____ Zip _____

Phone _____ Email _____

Alternate Contact Information _____

DEMOGRAPHICS

Race (check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Gender: ☐ Male ☐ Female ☐ Transgender (FTM) ☐ Transgender (MTF) ☐ Non-Binary ☐ Other ☐ Declined

Primary Spoken Language: ☐ English ☐ Spanish ☐ Other:_____

Primary Written Language: ☐ English ☐ Spanish ☐ Other:_____

Do you need language assistance (spoken or written)? ☐ Yes / Language _____ | ☐ No

HEALTHCARE PROVIDER

Nature of Employment/School: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student
Name of Employer/School: _____

Is your employment/education specialize in healthcare? ☐ Yes ☐ No
Is TCCHC your primary healthcare provider? ☐ Yes ☐ No

Tillamook County Community Health Centers
Administrative Office

503-842-3900 | 800-528-2938
TTY: 800-735-2900
Fax: 503-842-6099
tillamookchc.org
2204 4th Street | PO Box 489 | Tillamook, OR 97141

What type of insurance is your main way of paying for healthcare?

☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Self Pay

EDUCATION AND EXPERIENCE

Education Level: ☐ High School ☐ College 2 years ☐ College 4 years ☐ Graduate

Areas of expertise/experience/affiliations (check all that apply):

☐ Finance/Banking ☐ Legal ☐ Business ☐ Behavioral Health ☐ Healthcare

☐ Education ☐ Social Services ☐ Labor Relations ☐ Government ☐ Faith

☐ Other: _____

CONTRIBUTIONS AND INTERESTS (attach additional pages as needed)

1. Why do you want to be a Council member?_____

_____

2. What special contributions would you make as a Council member?_____

_____

3. Please list names of any current Council members that you know (if none, write n/a):

_____

4. Please list names of any relatives that are employed by the health center (if none, write n/a):

_____

5. Names and affiliation with other boards/councils for which you serve or have served in the last 2 years: _____

By signing and submitting this application, I agree to accept the responsibilities of the Community Health Council.

Signature of Applicant_____Date_____