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

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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. Do any immediate family members (ie spouse, child, parent, brother, or sister by blood, adoption or marriage) work at the health center?: Yes No

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

6. Meetings are held once a month, what is your availability (day, time)?

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

Signature of Applicant________________________Date_________________