Advisory Council Application

SE WA Aging & Long Term Care
Council of Governments

Southeast Washington ALTC Council of Governments

APPLICANT INFORMATION

Name: _____

Phone: _____ Date of Birth: _____

Email: _____

Mailing Address: _____ _____
Street *Suite/Apt*

_____ _____ _____
City *State* *Zip*

Physical Address: _____ _____
Street *Suite/Apt*

_____ _____ _____
City *State* *Zip*

Community Service Area of Interest:

Are you currently a participant of ALTC Services? ◯ Yes ◯ No

COMPLIANCE REQUIREMENTS

(Federal Register Vol. 45 No. 63 Composition of Council)

◯ Age 59 or under ◯ Age 60 or Over

RACE/ETHNICITY

☐ Caucasian ☐ African American ☐ Hispanic
☐ Native American ☐ Asian ☐ Other

If other, please specify:

EDUCATION

School name: _____
Location: _____
Degree Earned: _____ Major: _____

School name: _____
Location: _____
Degree Earned: _____ Major _____

WORK HISTORY

Employer: _____

Job Title: _____

Employer: _____

Job Title: _____

ADVISORY COUNCIL, BOARDS, COMMISSIONS EXPERIENCE *(current or previously served)*

TRAINING & EXPERIENCE BENEFICIAL TO SERVING ON THE ADVISORY COUNCIL

WHY ARE YOU INTERESTED IN SERVING ON THE SE WA ALTC ADVISORY COUNCIL?

I am available to accept an appointment to the SE WA Aging & Long Term Care Advisory Council
(not to exceed 3 years)

_____ _____

Signature *Date*

Please return this application to ALTC by:

Click this button to electronically submit your application

Email Application

OR

Print, scan, and email to:

ALTCAdvisoryCouncil@dshs.wa.gov

OR

Mail to:

SE WA ALTC COG
Attn: Clerk of the Board
PO BOX 8349
Yakima, WA, 9[illegible]