Sunshine Community Health Center

Sunshine Community Health Center is committed to accessible, proactive, quality health care, promoting community wellness through outreach and education.

Nomination Application for Board of Directors

PLEASE PRINT OR TYPE

Name: Last _____ First_____ Middle Initial _____

Address: (Physical) _____

(Mailing) _____

Telephone Number(s): Home _____ Work _____

Cell _____ Other _____

E-mail Address: _____

Occupation: _____ Employer: _____

Please answer the following questions for review.

1. Why do you want to serve on the Board of Sunshine Community Health Center?

2. Are you able to devote at least 10-12 hours per month to Board activities, such as sub-committee meetings? *Special projects could require more hours.* Yes No

3. Are you available to meet on the last Tuesday of each month at 6:30 p.m.? Yes No

4. What talents/skills do you feel you can contribute to the Board?

5. Do you have prior experience as a board member? Yes No
   If so, when and what organization(s) and position(s) did you serve?

6. Are you presently serving as a board member with organizations? Yes No
   If so, what are the names of the(se) organization(s)?

7. Have you used any SCHC services in either of the clinics in the past 12 months? Yes No

8. Do you have immediate family members employed at Sunshine Community Health Center? Yes No

9. Have you ever been convicted of a crime? No Yes

   If answering yes, when and for what: _____

   _____

We appreciate and thank you for your interest in Sunshine Community Health Center.

Signature: _____ Date: _____

Please use the space below for further explanations or comments.

Sunshine Community Health Center

BACKGROUND CHECK INFORMATION REQUIRED

Last Name _____ First Name _____ Middle _____

Other Names _____

Date of Birth: _____ City/State of Birth:_____

Driver's License No.: _____ State Dispensed: _____

Social Security Number: _____

Email: _____ Telephone No. _____

Physical Address & Date residence began:

_____

_____

Mailing Address:

_____

_____

Previous residences (city and state) – past ten years (need dates from – to month/year)

_____

_____

_____

_____

Gender: F M

Country: _____ Country of Citizenship: _____

Height: _____ft _____ in Weight (lbs) _____

Hair Color _____ Eye Color _____ Race: _____

Department of Health & Social Services
Background Check Unit

Disclosure of Personal History
&
Release of Information Authorization

Case Number (Eight Digit Number)

Applicants are required to disclose any known civil or criminal information regarding them which would be a barrier to association with the entity which is submitting your application for background check under AS 47.05. or 7 AAC 10.900 – 7 AAC 10.990. Please attach additional pages, if necessary, to complete the required information.

Have you ever been charged with, convicted of, found not guilty by reason of insanity for, or adjudicated as a delinquent for, a crime listed in 7 AAC 10.905?
No ☐ Yes ☐ If yes, please describe: _____

_____

Have you ever been found by a court or agency of this or another jurisdiction to have neglected, abused, or exploited a child or vulnerable adult under Children in Need of Aid (AS 47.10), Protection of Vulnerable Adults (AS 47.24), or Office of the Long Term Care Ombudsman (AS 47.62) or a substantially similar provision in another jurisdiction?
No ☐ Yes ☐ If yes, please describe: _____

_____

Have you been found by a court or agency of this or another jurisdiction to have committed medical assistance fraud under Medical Assistance Fraud (AS 47.05.210) or a substantially similar provision in another jurisdiction?
No ☐ Yes ☐ If yes, please describe: _____

_____

Have you appeared on the centralized registry established under Centralized Registry (AS 47.05.330) or a similar registry of this state or another jurisdiction?
No ☐ Yes ☐ If yes, please describe: _____

_____

Release of *information Authorization*

I certify that the contents of this form and information provided with it are true, accurate, and complete. I understand that a willful misrepresentation of the information provided is cause for immediate denial or later revocation of authorization under Criminal History; Criminal History Check; Compliance (AS 47.05.310).

I, the undersigned, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization will be held in confidence in accordance with DHSS guidelines.

I, the undersigned, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.

Applicant Signature	Date	Parent Signature (if applicable)	Date
Applicant Printed Name	Applicant SSN	Parent Printed Name	

Form revised February 22, 2007