

COLUMBIA COMMUNITY MENTAL HEALTH

BOARD MEMBER INTEREST FORM APPLICATION

Thank you for your interest in Columbia Community Mental Health. To more thoroughly assess the qualifications of persons interested in serving on the CCMH Board of Directors, you are requested to fill out this interest form application as completely as possible. You are encouraged to attach additional supplemental information or a resume which further details your involvement in volunteer activities, public affairs, civic services, published writing, affiliations, etc.

CCMH is a non-profit provider that relies on federal, state, and grant funding to supplement low insurance reimbursement, clients with limited resources and complete write-offs due to inability to pay. CCMH frequently provides essential resources to clients who are at or below the poverty level for no cost reimbursement. These essential items include, but are not limited to: rent payments, food and transportation. As a member of the CCMH board, your donation to these reserved, unrestricted dollars for non-reimbursable services is greatly appreciated and represents a vested interest in the mission of CCMH to “create safe and supportive opportunities for healing and recovery, enhancing the overall quality of life for members of Columbia County”.

A. Personal Information

Name _____

Mailing Address _____ City _____

State _____ Zip Code _____ Columbia County Resident? Yes _____ No _____

Home Phone _____ E-Mail Address: _____

B. Why are you interested in serving on the CCMH Board of Directors?

C. In addition to serving as a CCMH Board member would you be interested in serving on one of the following Board Committees and why:

1) Budget & Finance Committee and/or 2) Audit & Oversight Committee

D. Current Employer _____ Address _____
City _____ State _____ Zip Code _____ Work Phone _____
Your Job Title _____

Where would you like mail delivered: Home _____ Work _____

E. Please list all current and past volunteer activities.

Name of Organization	Dates	Responsibilities
_____	_____	_____
_____	_____	_____
_____	_____	_____

F. Please list all education.

Name of School	Dates	Responsibilities
_____	_____	_____
_____	_____	_____

G. Please list the name, address, and telephone numbers of two people who may be contacted as references who know about your interests and qualifications to serve on the CCMH Board.

Name	Telephone
_____	_____
_____	_____

My signature affirms that all information is true to the best of my knowledge and that I understand that any misstatement of fact or misrepresentation of credentials may result in this application being disqualified from further consideration or subsequent to my appointment to a board/committee may result in my dismissal.

NOTE: Applications will be held for one (1) year from date of receipt. All information on this application is considered public record and may be made available upon request.

Signature _____ Date _____

Please complete and return to:
Columbia Community Mental Health
Board Secretary
P.O. Box 1234
St. Helens, OR 97056

In accordance with Federal civil rights laws, CCMH, its offices and employees, are prohibited from discriminating based on race, color, origin, religion, sex, gender identity, sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by CCMH.