West Coast District Health Board

WCDHB Advisory Committee Membership Application Form

SURNAME _____ **FIRST NAMES** _____

ADDRESS _____

PHONE NUMBERS **Home** _____ **Work** _____ **Mobile** _____

FAX NUMBER _____ **EMAIL ADDRESS** _____

PLEASE INDICATE WHICH COMMITTEE(S) YOU ARE INTERESTED IN BECOMING A MEMBER OF:

Community and Public Health ☐ **Hospital Advisory** ☐

Disability Support ☐

SKILLS:	*Please indicate the skills that you possess that you feel would be beneficial to the committee(s) you are interested in*
EXPERIENCE IN WORKING WITH COMMUNITIES:	*Please detail relevant experience you possess in working with community groups*
EXPERIENCE IN WORKING WITH MAORI COMMUNITIES:	*Please detail your previous experience that you have in working with Maori groups*

OTHER RELEVANT SKILLS:	***Please detail any other relevant skills that you think you will bring to the committee(s) you are interested in***
AVAILABILITY FOR MEETINGS:	***Please detail your availability to attend regular monthly meetings of the committee(s) you are interested in***
AREAS OF POSSIBLE CONFLICT OF INTEREST:	***Please read the information on conflicts of interest and detail any possible conflicts of interest that you may have with the committee(s) you are interested in***
REFERENCES:	***Please provide contact details for 2 persons who have known you for more than 5 years and can be contacted to provide a character reference for you***

Name _____ **Relationship** _____ **Phone Nos** _____

Name _____ **Relationship** _____ **Phone Nos** _____

DECLARATION

I consent to the West Coast District Health Board obtaining this information from myself. This consent holds to the West Coast District Health Board using this information for establishing my suitability for appointment to an Advisory Committee. I also consent to the West Coast District Health Board disclosing this information to any person or agency that has jurisdiction over, or relating to, or touching the appointment process, subject to the requirements of the Privacy Act 1993. I also understand that if appointed by the West Coast District Health Board, this information will be placed on file and I have the right to access and correct it. If the West Coast District Health Board does not appoint me, I understand that this information will be shredded following the selection process. I declare that to the best of my knowledge the information above is entirely true and correct and I understand that if any false information is given or relevant material suppressed or not supplied I may not be appointed or if appointed subject to appropriate disciplinary action, which may include removal form the Advisory Committee.

Name _____ **Signature** _____ **Date** _____

Once Completed Please Return To:
Office of the Chief Executive Office
West Coast District Health Board
Freepost 164826
P.O. Box 387
GREYMOUTH