KENTUCKY DEPARTMENT FOR PUBLIC HEALTH
BIOGRAPHICAL SHEET - COUNTY BOARD OF HEALTH NOMINEE
Serving Term Beginning January 1, _____ through December 31, ______
(2 year term)

PLEASE PRINT ALL INFORMATION AND CHECK APPROPRIATE BOXES

As stated in KRS 212.020, the members of the local board shall hold office for a term of two (2) years with the terms of ***physicians, dentists, pharmacists, and fiscal court appointees beginning on January 1st during*** even-numbered years and the terms of ***nurses, engineers, optometrists, veterinarians, and consumer lay appointees*** beginning on January 1st during odd- number years.

General Information

______Miss ______Mrs. ______Ms. ______Mr. ______Other (MD, RN, RPh. Etc.)

Name: ____

Mailing Address: **Street** ______________________________ **P.O. Box #** _______

City ______________________________, **Kentucky Zip**___________

County of Legal Residence______________________________

Home Phone: (____) ______________________________

Employment Information

Place of Employment (company/agency name)______________________________

Phone: (__) ______________________________

Do you or your employer have a contract(s) with any county health department? Yes__ No__

Consumer Representative: __________ **Fiscal Court Representative** __________

Professional Representative: **___Physician ___Dentist ___Registered Nurse __Optometrist**

___Engineer ___Veterinarian ___Pharmacist

Kentucky License/Registration Number: ________________________ **Provider #**________________
(Must Complete)

Practicing: ______Yes ______No **Retired: _____Yes _________No**

LAY REPRESENTATIVE

(To be used only when a professional member is not available or unwilling to serve)

Representing: **__Physician __Dentist __Registered Nurse __Optometrist**

__Engineer __Veterinarian

-OVER-

Are you currently serving as an elected member of a School Board? __Yes __No

Is this a (__) new appointment or (__) reappointment?

If a reappointment, how long have you served on the board? _____0-5yrs _____6-10yrs _____11-15yrs _____16-20yrs _____20+yrs

Certain demographic information is essential to assure compliance with the Civil Rights Act of 1964 and state administered programs using federal funds. Other information is needed to assure that each board is diversely representative of Kentucky's citizens.

Please complete the following information:

1. **Race:** ______White
   ______African American
   ______Asian/Pacific Islander
   ______American Indian/Alaskan Native
   ______Hispanic

2. **Age:** ______0 to 21
   ______22 thru 39
   ______40 thru 54
   ______55 and over

3. **Gender:** ______Male ______Female

4. **I have a disability.** ______Yes ______No

5. **I am a veteran.** ______Yes ______No

THE CABINET FOR HEALTH AND FAMILY SERVICES DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, RELIGION, AGE OR DISABILITY IN MAKING APPOINTMENTS TO BOARDS AND COUNCILS.

______________________________ ______________
(Signature of Nominee) **(Date)**

Submitted By: ______________________________ **Date:** ______________

Agency/Organization: ______________________________ **Date:** ______________

MAIL YOUR NOMINATIONS TO:

ATTN: STEPHANIE SCHWEIGHARDT
DIVISION OF ADMINISTRATION & FINANCIAL MGMT
275 EAST MAIN STREET, HS1W-C
FRANKFORT, KY 40621
QUESTIONS? CALL (502) 564-6663 Ext. 3060, fax: (502) 564-0919