VENTURA COUNTY
HEALTH CARE AGENCY

Healthcare Equity Advisory Council

Application for Membership Appointment

Thank you for your interest and applying for appointment consideration to the Healthcare Equity Advisory Council. Please complete this application and return it to HEACapplications@ventura.org along with any additional information you would like to be considered such as a resume.

Name: _____
FIRST MIDDLE LAST

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **E-mail:** _____

Language(s) Spoken/Written:

_____

Which of the following best describes you? ***(optional, check all that apply)***

□Man □Woman □Agender □Genderqueer/ Non-binary/ Gender non-conforming

□Trans Man □Trans Woman

□Not listed and wish to share: _____

Pronoun(s): _____

Which of the following best describes you? ***(optional, check all that apply)***

□ Asian or Pacific Islander □Black or African American □Hispanic or Latino or Latinx

□White or Caucasian □Indigenous □American Indian or Alaska Native

□Multiracial or Biracial

□Not listed and wish to share: _____

How can your lived experience help HEAC understand how racism and other inequities (such as those involving gender identity, ethnicity, disability, sexual orientation, etc.) impact healthcare?

_____

_____

_____

_____

What do you hope to contribute as a member of the Healthcare Equity Advisory Council?

_____

_____

_____

_____

Is there anything else you would like to us to know about your interest to address issues of health disparities and inequities in Ventura County?

_____

_____

_____

_____

Are you able to dedicate 2-5 hours per month toward the work of the council? ☐ YES ☐ NO

Do you have any economic or personal conflict of interests with the Health Care Agency? ☐ YES ☐ NO

If Yes, explain: _____

_____

How did you hear about applying for the Health Equity Advisory Council?

_____

Submission of this application does not guarantee you will be selected to serve. To allow for group continuity, initial members will be appointed to two or three-year terms. This application will be maintained for a period of one year. After one year, it is necessary to file a new application for another year of eligibility for consideration for appointment. Appointees are not considered to be County employees for the purposes of benefits, such as worker's compensation, health insurance, etc.

Return Completed Application to:
Health Care Agency
5851 Thille Street, 1st floor
Ventura, CA 93003
or email to:
HEACapplications@ventura.org

THIS APPLICATION IS A PUBLIC RECORD AND SUBJECT TO DISCLOSURE

Applicant's Signature

I certify that, to the best of my knowledge, all statements in this application are complete and true. I further certify that if I am appointed, I will serve fairly, impartially and to the best of my ability. I agree and understand that any misstatement of material fact will cause me to forfeit all rights to appointment to the Health Equity Advisory Committee with the County of Ventura.

_____ _____

SIGNATURE DATE