

CITIZEN'S ADVISORY BOARD APPLICATION

Ohio Department of Mental Health

Name (last, first, middle)		Address (street, city, state, county, zip)	
Home Telephone No.	Employer	Employer's Address	
Business Telephone No.	Occupation	Preferred Mailing Address <input type="checkbox"/> Home <input type="checkbox"/> Business	
"X" One <input type="checkbox"/> Provider of Mental Health Services <input type="checkbox"/> Non-Provider of Mental Health Services		"X" if Applicable <input type="checkbox"/> Parent of BHO Patient <input type="checkbox"/> Patient of BHO <input type="checkbox"/> Relative of BHO Patient <input type="checkbox"/> Former Patient	
Education			
Type	Name and City of School	Year Graduated	Degree
High School			
College			
Other			
Employment History			
Name, City, & State of Employer (start with most recent employment; list last 10 years only)		Dates	Position Held
Community Affiliations (past or present)			

Why are you interested in serving as a member of a state BHO Citizen's Advisory Board?			

Previous Service as a Citizen's Advisory Board Member			
From	To	BHO	

I wish to apply for membership on the Citizen's Advisory Board of:

Name of BHO	Signature	Date
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Recommended for Appointment By	<input type="checkbox"/> New Term <input type="checkbox"/> Fill Unexpired Term of _____		
Application <input type="checkbox"/> Approved <input type="checkbox"/> Rejected	Application <input type="checkbox"/> Approved <input type="checkbox"/> Rejected		
Department of Mental Health Director	Joint Committee Chairperson or Designee		
Appointed to Citizen's Advisory Board of (name of BHO)		Term Begins	Term Ends