Pain Management Commission Interest Form

The purpose of this form is to assist the Department of Human Services Director and staff in evaluating the qualifications of an applicant for appointment to the Pain Management Commission. Please complete the entire form and return to:

Pain Management Coordinator
Office of the Director, Department of Human Services
500 Summer Street NE, E-17 Salem, OR 97301-1079
Fax: (503) 378-6532, Telephone: (503) 945-7009

The Pain Management Commission shall consist of 19 members as follows:
(Please place a check mark next to the Commission position for which you are applying.)

filled Two: Licensed Physician under ORS chapter 677, or organizations representing physicians;

filled One: Licensed Nurses under ORS chapter 678, or organizations representing nurses;

filled One: Licensed Psychologist under ORS 675.010 to 675.150 or organizations representing psychologists;

filled One: Licensed Physician Assistant under ORS 677.495 to 677.545 or organizations representing physician assistants;

___ One: Licensed Chiropractor under ORS 684 or organization representing chiropractic physicians;

___ One: Licensed Naturopath under ORS chapter 685 or organizations representing naturopath;

filled One: Licensed Clinical social worker under ORS chapter 675 or organization representing clinical social workers;

___ One: Palliative care professionals or organizations representing palliative care professionals;

___ Two: Mental health professionals or organizations representing mental health professionals;

filled One: Health care consumers or organizations representing health care consumers;

filled One: Hospitals and health plans or organizations representing hospitals and health plans;

___ Two: Patients or advocacy groups representing patients; (not represented in the categories above)

Two: Members of the public (not represented in the categories above)

Two additional members shall be members of a legislative committee with jurisdiction over human services issues. The term of office for each member is four years. However, the member serves at the pleasure of the appointing authority.

Personal Data

Preferred Mailing Address: Home __ Business __

Preferred Title _____________

First Name ____________ MI ___ Last Name _________________________

Home Address:

____

____

City ________________________________ State ______ Zip _______

County ______________________

Spouse's Name (optional) __________________________________

Business Name

____

Address

____

____

City ________________________________ State ______ Zip ___________

Occupation

____

Home Phone (_____) _________ Business Phone (_____) _________ext_____

Fax (_____) ____________________

Email address ____

To assist us in meeting our affirmative action objectives, we would appreciate information about your gender and background. This information is optional. Under state and federal law, this information may not be used to discriminate against you.

Gender	**Race/Ethnic**		**Disability**
__Male	__Asian or Pacific	__Native American	___________________________________
__Female	__Black	__White	
	__Hispanic	__Multiracial/Other	

Education

Schools attended, include high school. *A current resume may be substituted for this section.*

School	**City & State**	**Dates**	**Degree/Major**

Employment & Experience

List major paid employment & significant volunteer activities. List chronologically beginning with most recent experience.
A current resume may be substituted for this section.

Dates (from-to) **Employer/Organization** **City & State** **Title/Position**

Interest in Appointment

Describe in detail why you are interested in serving on this commission. Include information about your background that supports your interest. *You may complete this section on a separate sheet.*

Signature_______________________________________ Date __________________

Pain Management Commission Appointment Background Information

Furnishing the following information is voluntary, but failure to provide the requested data may preclude selection for appointment. *This page will be deemed to have been submitted to the Department of Human Services director in confidence*. Accordingly, pursuant to ORS 192.502(3), this information will not be made available to public inspection. I hereby authorize the State Department of Police and the Department of Human Services to obtain any and all records pertaining to me on file with the Department of Revenue, the Motor Vehicles Division, law enforcement agencies, credit references or bureaus, and past and present employers, business associates, and acquaintances.

Signature____________________________________ Date _____________

If your answer to any of the following is "yes", please give full details on the back of this page or a separate sheet of paper.

(a) Have you ever been a defendant in a civil action? Do not include cases in which you were included as a nominal defendant with no potential liability, such as mandamus actions.

Yes_____ No_____

(b) Have you ever filed for bankruptcy?

Yes_____ No_____

(c) Have you ever been convicted or have you pleaded guilty to any crime or violation? Do not include minor traffic offenses resulting in fines of less that $100.

Yes_____ No_____

(d) Have you ever been the subject of any professional disciplinary proceeding or had any professional license or permit revoked or restricted?

Yes_____ No_____

The Department of Human Services director's staff and the Oregon State Police may conduct a background investigation to obtain information about you. Please provide the following information and sign above to permit the investigation to be conducted.

Name and Home Address:

First____________________ MI_____ Last______________________________

Street____

City ____________________________________ State____ Zip______________

Social Security Number _______-_____-________

Driver's License No.__________ State____

Date of Birth______/______/______ Place of Birth _____________________

Professional Licenses Held____

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