Palliative Care and Quality of Life Interdisciplinary Advisory Council Application/ Interest Form

The purpose of this form is to assist the Oregon Health Authority Director and staff in evaluating the qualifications of an applicant for appointment to the Palliative Care and Quality of Life Interdisciplinary Advisory Council.

Please complete the entire form and return to:

Palliative Care Advisory Council Coordinator
Oregon Health Authority
421 SW Oak St. Suite 775
Portland, OR 97204
Fax: (503) 378-5511, Telephone: (971) 208-1855
Email: mark.g.altenhofen@dhsoha.state.or.us

The Palliative Care and Quality of Life Interdisciplinary Advisory Council shall consist of 9 members. Members will have interdisciplinary palliative care experience with children, youths, adults and elderly.
(Please place a check mark next to all that apply.)

_____ Physician

_____ Certified in Palliative Care

_____ Nurse

_____ Certified in Palliative Care

_____ Clinical social worker

_____ Pharmacist

_____ Clergy or other with professional spiritual expertise;

_____ Other expertise in interdisciplinary palliative care

Please specify _____

The term of office for each member is three 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 _____

Business Name_____

Address _____

City _____ State _____ Zip _____

Occupation _____

Home Phone _____ Business Phone _____

Fax _____ Email _____

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

Male _____ Female _____

Disability _____

Race/Ethnicity

Asian _____
Pacific Islander _____
Black _____
Hispanic _____
Native American _____
Caucasian _____
Multiracial/Other _____

Education and Certification

Schools attended. *A current resume or CV may be substituted for this section.*

School	City & State	Dates	Degree/Major

Certifications:

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	Employer/Organization	City/State	Title/Position

Interest in Appointment

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

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Signature_____ Date _____

Palliative Care and Quality of Life Interdisciplinary Advisory Council
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 Oregon Health Authority 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 Oregon Health Authority 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 less than $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 Oregon Health Authority 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_____