



Board of Directors Membership Application

Name: _____ Date: _____

Business/Employer: _____ Title: _____

Business Address: _____

Home Address: _____

County in Which you live: _____ County in Which you work: _____

Please send mail to: Home Work Call at work: Yes No

Date of Birth: _____

Work Phone: _____ Fax: _____

Home Phone: _____ Email: _____

So that we may match your talents, skills, experience and personal interests with our needs, please complete the following.

Field of Education or Training: _____

Employment Experience/Skills: _____

Community Service Experience/Skills: _____



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I am willing to serve on the following committees:

Executive Finance Nominating Performance Improvement/QI Building

Are you a patient of South Central Medical Center: YES NO

If you are a patient of SCMC, approximately when were you last seen by your provider? _____

Note: patient board members must maintain their "patient status" by complying with a minimum of at least one (1) primary care visit per year.

Are you able to commit to attendance at monthly meetings of the Board? YES NO

I wish to apply for membership on the Board of Directors of South Central Medical Center. My signature below signifies my agreement to be interviewed by the Nominating Committee and serve if selected.

Signature

Date