



BOARD OF DIRECTORS
Membership Application

Community Health Partners' (CHP) mission is to enhance community health and well-being through Innovative Programming, Strong Partnerships, and Improved Outcomes.

Date: _____

Name: _____

Address: _____

City: _____ MT Zip _____

Phone: (406) _____ Alt Phone: _____ Mobile: _____

Email: _____

Present Occupation if employed:

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

For the following questions, please feel free to continue on a separate piece of paper.

Please list any other organizations in which you have been involved and how those may complement your role as a CHP Director.

Education: Please list any special education, experience and/or training that will support your role as a Board Member of the CHP:

Public Relations/Marketing: Please list any experience you may have in public relations, public speaking, broadcast or print media, or marketing:

Financial Development: Please list any relevant experience you may have in fundraising, financial planning, recruitment, grant writing, or accounting.

Patient at CHP/GCC: Yes No If yes, for how long and what are your impressions?

Your Role: Please provide a brief summary of your understanding of your role as a Board Member and a short description of what you hope to add to the CHP. Please include what you hope to gain from this experience:

Please check any of the topics below where you have experience and/or special interest:

<input type="checkbox"/>	Advocacy	<input type="checkbox"/>	Education	<input type="checkbox"/>	Research
<input type="checkbox"/>	Community health	<input type="checkbox"/>	Legal issues	<input type="checkbox"/>	Fundraising
<input type="checkbox"/>	Communications	<input type="checkbox"/>	Strategic Planning	<input type="checkbox"/>	Organization structure
<input type="checkbox"/>	Coalition Building	<input type="checkbox"/>	Financial development	<input type="checkbox"/>	Leadership development
<input type="checkbox"/>	Business Relations	<input type="checkbox"/>	Corporate giving	<input type="checkbox"/>	Administration
<input type="checkbox"/>	Poverty issues	<input type="checkbox"/>	Planned giving	<input type="checkbox"/>	Finance & administration
<input type="checkbox"/>	Medicine	<input type="checkbox"/>	Public relations/image	<input type="checkbox"/>	Patient – Insider Information

The Board of Directors meets once/month. In addition, the Board occasionally holds committee meetings. Please indicate your willingness to meet attend all these meetings by initialing: ____ I understand that if I am unable to attend, I must contact the CHP Executive Director or Board Chair for an excused absence. Failure to attend more than three unexcused meetings in a year, may result in my being removed from the Board.

Personal references: Please list at least 3 with phone numbers.

Signature of Applicant: _____ Date: _____

THANK YOU FOR YOUR INTEREST.

ATTN: P Brant Robey, Chair
 CHP Board of Directors
 126 South Main Street
 Livingston, MT 59047

www.chphealth.org
francisl@chphealth.org