District Health Advisory Council Application Form

Community and Consumer Representative

Name _____ Preferred Name _____

Address _____

Phone Number _____ Date of Birth _____

Email _____

Gender Identity _____ Preferred Pronouns he/him ◯ she/her ◯ they/them ◯

DHAC you are nominating for _____

Do you identify with any Ethnicity? (please specify) _____

I am nominating as a (please tick the appropriate box)

◯ **Health Consumer** – A person who directly, or through family/friend uses the public hospital or community health services in the district and wishes to bring a consumer perspective to the DHAC.

◯ **Community Member** – A person who wishes to represent a broad or specific community perspective other than that of a health consumer e.g. aged, Aboriginal, youth, chronic disease.

◯ **Both**

Please outline your key area/s of interest related to health services in your area:

_____

_____

_____

_____

Please identify which groups below you represent:

◯ Aboriginal and Torres Strait Islander People
◯ Cultural and Linguistically Diverse
◯ Town or Community
◯ Youth (16-25)
◯ Child Health/Early Intervention
◯ Other (please specify) _____

◯ Carers
◯ People with Chronic Disease or Disability
◯ Women's Health
◯ People Experiencing Homelessness
◯ Mental Health

◯ Older Adults
◯ Men's Health
◯ LGBTIQ+SB

Please identify the consumer or community perspective you bring to the Council e.g. youth, Aboriginal health, aged care, chronic disease or consumer advisory:

Please identify the town/community you wish to represent: _____

Do you or your family use local hospital or community health services in the area?

◯ **Yes** ◯ **No**

What is your interest in consumer rights and responsibilities?

Have you had previous experience on a Board or Advisory/Task Group?

What past experience do you have that will help in your role as a Council member?

Direct experience as a consumer, a carer, or via a family member or friend.
Interest in improving health for a particular group.
Other roles involving community affairs.

Other comments:

Applicant's Signature _____ **Date** _____

Please return this Application Form to the WACHS Regional Office in your area. Choose an item.

Goldfields - wachs-goldfieldsexec@health.wa.gov.au

CM ED-CO-23-177334

WACHS Office use only

Approved	Yes ◯	No ◯	Date
Operations Manager Name		Operations Manager Signature	
CM link to DHAC member folder		CM link to signed confidentiality agreement	

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