



District Health Advisory Council Application Form

Health Service or Agency 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 Service Provider**

☐ **Agency Representative**

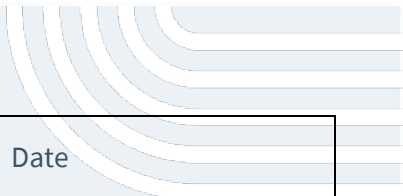
Name the health service/agency you represent in this role _____

Please outline your or your agency's key areas of interest related to health services in your area:

What will you bring and contribute to the Health Advisory Council?



Date _____



WACHS Office use only

Approved	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date
Operations Manager Name		Operations Manager Signature	
CM link to DHAC member folder		CM link to signed confidentiality agreement	

