District Health Advisory Council Re-Nomination 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) _____

DHAC member since _____

I am re-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:

_____

_____

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_____

For your Health Service Manager or Agency Chairperson to complete:

Approval for applicant to represent the Health Service/Agency on the District Health Advisory Council is:
Supported ◯ Not supported ◯

Manager/Chairperson name _____

Position _____

Signature _____ Date _____

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

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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