



# 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:**

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

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**What is your interest in consumer rights and responsibilities?**

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What previous experience do you have on a Board or Advisory Group?

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Please include any other information to support your application:

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For your Health Service Manager or Agency chairperson to complete:

Approval is supported / not supported for applicant to represent the Health Service/Agency on the District Health Advisory Council

Manager/Chairperson name \_\_\_\_\_

Position \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Comments

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Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

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

WACHS Office use only

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

