

**DEPARTMENT OF HEALTH**  
**Health Systems Quality Assurance Division**  
**Office of Community Health Systems**

***Regional EMS and Trauma Care Council***  
**MEMBERSHIP APPLICATION**

Please print all information and complete both sides of this application.

1. I, \_\_\_\_\_ am applying for appointment / reappointment  
(Circle One Above)  
as the \_\_\_\_\_ representative on the  
(please specify if "alternate")  
\_\_\_\_\_ Region EMS/Trauma Care Council from \_\_\_\_\_ County.

2. Preferred mailing address for Regional Council business:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact information:

Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_

FAX (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

3. **LOCAL EMS COUNCIL RECOMMENDATION:**

Chair / President: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

4. Complete if you are formally representing an agency or organization:  
*(attach any letters of recommendation)*

Agency / organization name: \_\_\_\_\_

Head of organization: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Over)**

5. Please answer the following:

a) Why are you interested in serving on the Regional Council?

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b) What are your abilities, i.e., education, employment and/or experience that qualify you for this position? (attach any additional information)

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c) Current employment: \_\_\_\_\_

<hr/> Applicant Signature	<hr/> Date
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**Return completed form to:**

Shaughn Hill  
Regional Council Appointments Coordinator  
Office of EMS and Trauma System  
PO Box 47853  
Olympia, WA 98504-7853

**Questions?** Call Shaughn at (360) 236-2868.

**Personal Information (Optional):**

*NOTE: The Governor and the Department of Health desire a broad representation of backgrounds on boards, committees and councils. The information below will assist in this goal and is voluntary on your part.*

Of what race or ethnicity do you consider yourself to be?

- Black/African-American
- Asian or Pacific Islander American

- White/Caucasian
- American Indian or Alaska Native

- Latino(a), Hispanic, or Spanish?

*If you are Asian or Pacific Islander, please check one box below:*

- Chinese
- Vietnamese
- Filipino
- Asian Indian
- Hawaiian
- Japanese

*If you are American Indian or Alaska Native, please check one box below:*

- Eskimo
  - Aleut
- Enrolled or principal tribe if American Indian:*

*If you are Latino(a), Hispanic, or Spanish, please check one box below:*

- Mexican, Mexican-American, Chicano
  - Puerto Rican
  - Cuban
  - Other Latino(a), Hispanic, or Spanish
- Enter group, such as Colombian, Dominican, etc.*

- Korean
- Cambodian

Tribe: \_\_\_\_\_

Group: \_\_\_\_\_

- Samoan
- Laotian
- Guamanian
- Other: \_\_\_\_\_

- Other Race: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Female  Male

Do you have a permanent physical, sensory, or mental condition that substantially limits your major life functions, such as working, caring for yourself, walking, doing things with your hands, seeing, hearing, speaking, and learning?  Yes  No

Have you ever been on active duty in the U.S. Armed Forces?  Yes  No