



**Bureau of HIV/AIDS
Membership Application Form**

The Florida Department of Health, Division of Disease Control, Bureau of HIV/AIDS is committed to recruiting members to serve on advisory groups, committees and other ad hoc committees/groups to assist the bureau in addressing HIV/AIDS policies, programs, issues and concerns. These committees/groups are discretionary bodies formed by the Bureau of HIV/AIDS to represent people living with HIV/AIDS and individuals at high and increased risk. These committees/groups will also serve affected communities, community-based organizations and AIDS service organizations. The Bureau of HIV/AIDS reserves the right to remove an individual from a committee/group due to lack of participation, attendance or behavior. Each individual selected will serve two-year terms members are expected to attend meetings, conference calls and maintain an ongoing engagement with organizations and individuals from the group they represent. The individual participation on the committee/group will be re-determined after the completion of his/her second term.

The primary responsibilities of the committee/group will be defined in a separate letter when the application for membership is disseminated. The letter will clearly define the name of the committee/group, purpose and the selection process. Members of the committee/group will be required to attend an orientation, as well as attend face-to-face meetings and conference calls. If a member misses more than three or more conference calls within a year, the member is subject to removal from the committee or group.

A separate membership application must be submitted for each committee or group you would like to join. Individuals interested in being considered for membership should complete and mail or fax the attached form to:

Florida Department of Health
Bureau of HIV/AIDS
4052 Bald Cypress Way, Bin A-09
Tallahassee, Florida 32399-1715
Attention: Bruce Campbell
Consumer Advisory Group Liaison
Fax Number: (850) 414-6719

For additional information, please contact Bruce Campbell at (850) 245-4444 ext. 2540.

Category of Representation (check all that apply to you):

<input checked="" type="checkbox"/>	Individual living with HIV or AIDS
<input type="checkbox"/>	Affected communities: including populations hard-hit with HIV and historically underserved groups
<input type="checkbox"/>	AIDS service organization and/or community-based organization
<input type="checkbox"/>	Health care provider
<input type="checkbox"/>	Social service provider
<input type="checkbox"/>	Mental health provider
<input type="checkbox"/>	State or local government: Specify:
<input type="checkbox"/>	Former Prisoner and/or their representative
<input type="checkbox"/>	Part A, B, C, or D grantee
<input type="checkbox"/>	Non-elected community leader
<input type="checkbox"/>	Other: Specify:

Please answer the following questions as completely as possible (use the back a separate page if necessary):

What particular skills or expertise would you bring to the committee/group?

Have you had any experience participating in community planning, health planning, or other similar group planning processes? If so, please describe.

Why are you interested in becoming a member of the Bureau of HIV/AIDS committee/group?

In the HIV/AIDS Program, HIV prevention and care are top priorities. Please describe what components you feel need to be in place in a community to prevent HIV and to provide care to those individuals who are infected?

The Consumer Advisory Group is in agreement to disclose their HIV status openly on the Bureau website and for public engagements. Are you willing to be in the public's eye with your HIV status?

Is there any additional information you would like us to consider when reviewing your application?

Signature

By signing this Application Form, I certify that all information contained herein is true and accurate to the best of my understanding. I also certify that I have read and understand the membership requirements outlined on Page 1 of this form and, if accepted for membership, will fulfill all membership requirements as put forth by the Bureau of HIV/AIDS.

Signature: _____
Signature Required

Date Submitted: _____

Additional materials may also be attached and submitted for consideration.