HEALTH PROFESSIONS EDUCATION FOUNDATION
Giving Golden Opportunities

Licensed Mental Health Service Provider Education Program Advisory Committee Application

Thank you for your interest in serving on the Licensed Mental Health Service Provider Education Program Advisory Committee. Please complete the information below and include a copy of your current résumé.

Name: _____

Title: _____

Organization: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: ( ) _____ Fax: ( ) _____

e-mail: _____

Ethnic background/affiliation (optional):

☐ African American ☐ Asian American/Pacific Islander ☐ Caucasian
☐ Hispanic ☐ Native American ☐ Other: _____

Please answer the following questions (attach additional page, if necessary):

1. Describe your involvement in mental health education programs.

2. Describe your interest in serving on the Licensed Mental Health Service Provider Education Program Advisory Committee.

3. What strengths, contributions, and resources would you bring to the Licensed Mental Health Service Provider Education Program Advisory Committee?