



BOARD OF DIRECTORS MEMBERSHIP APPLICATION

Name: _____

Date: _____

Business/Employer: _____

Title: _____

Business Address: _____

Home Address: _____

Please send mail to: Home Work

Call at Work: Yes No

Date of Birth: _____

Work Phone: _____

Fax: _____

E-mail: _____

Home Phone: _____

So that we may match your talents, skills, experience and personal interests with our needs, please complete the following and attach your resume:

Field of Education or Training: _____

Employment Experience/Skills: _____

Community Service Experience/Skills: _____

I am willing to serve on the following committee(s):

- Compliance/Quality Improvement
- Executive
- Finance
- Governance
- Strategic Planning

Are you a patient of Seabasticook Family Doctors? Yes No

If you are a patient of SFD, approximately when were you last seen by your Provider? _____

Note: patient Board members must maintain their "patient status" by complying with a minimum of at least one (1) primary care provider visit per year.

Are you able to commit to attendance at monthly meetings of the Board? Yes No

Each member of the Board of Directors must agree to background checks from the following entities:

- Office of the Inspector General Exclusions from Federally Funded Health Care Programs
- State Bureau of Identification (Criminal Convictions)
- Maine Department of Health and Human Services - Child Protective Services

I wish to apply for membership on the Board of Directors of Seabasticook Family Doctors. My signature below signifies my agreement to have the above background checks performed upon my initial application and on an ongoing basis thereafter.

Signature

Date