



NEW BOARD MEMBER APPLICATION

Please fill out this application so we may get to know you better. Once complete, your application will be reviewed and voted on at the next regular board meeting. Thank you for your interest in WellSpring!

CONTACT INFORMATION

| | |
|---------------------------|--|
| Name: | |
| Organization: | |
| Mailing Address: | |
| City, State, Zip: | |
| Best Phone Number: | |
| E-mail Address: | |

Please indicate all Community Sectors that represent your work (paid or volunteer):

- | | | |
|---|--|--|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Youth | <input type="checkbox"/> School |
| <input type="checkbox"/> Business | <input type="checkbox"/> Media | <input type="checkbox"/> Faith Based |
| <input type="checkbox"/> Youth Serving Organization | <input type="checkbox"/> Health Care | <input type="checkbox"/> Civic Organization |
| <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Prevention | <input type="checkbox"/> Government |
| <input type="checkbox"/> Substance Abuse Counseling | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Other (please specify): |

What kinds of activities/issues are you interested in? (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Parenting | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Underage Tobacco Use | <input type="checkbox"/> Alcohol Abuse/Underage Use | <input type="checkbox"/> Prescription Drug Abuse |
| <input type="checkbox"/> Public Relations | <input type="checkbox"/> Coalition Capacity/Training | <input type="checkbox"/> Other (specify) _____ |

1. What life experience (personal or professional) will you bring to the Network?

2. Have you served on any other community board, commission, council, volunteer organization, or professional association? If yes, please list:

3. What do you hope/expect to receive from this experience?

Personal References: **Please provide the names of two, non-relative references*

1. Name: _____ Phone: _____
Address: _____ Relationship: _____

2. Name: _____ Phone: _____
Address: _____ Relationship: _____

I give my permission for the named references* to be contacted either verbally or in writing. All the information on this application is true to the best of my knowledge.

Signature _____
Date _____

We welcome your willingness to serve! Please return this completed form to:

WellSpring Community Network
PO Box 170
Long Beach, WA 98631