SUD POLICY OVERSIGHT BOARD COMMITTEE MEMBER PROFILE

NAME:
OCCUPATION:
SOCIAL SECURITY NUMBER:
HOME ADDRESS:
HOME TELEPHONE NUMBER:
BUSINESS ADDRESS:
BUSINESS TELEPHONE NUMBER:
E-MAIL ADDRESS:
I WOULD PREFER HAVING BOARD MATERIALS SENT TO MY: o **HOME** o **OFFICE**

AS A BOARD MEMBER, I CAN REPRESENT THE FOLLOWING PERSPECTIVES (CHECK ☑ AS MANY AS APPLY):

	Healthcare Field		Family of Individual in SUD Services (past or present)
	Business		Government
	Citizen-At-Large		SUD Professional
	Primary Consumer: An individual who has received or is receiving services from a Substance Use Disorder Treatment Provider or a Community Mental Health services program (for co-occurring MH and SUD) or services from the private sector equivalent to those offered by the department or a community mental health or SUD services program.		Mental Illness/Co-occurring Professional
			Multi-Cultural/Minority
			Parent of individual in SUD Services (past or present)
			Provider
			Volunteer
	Individual in Recovery		Other:
	Education		

CONFLICT OF INTEREST STATEMENT

I understand the concept of Conflict of Interest and represent that I will not knowingly be party to a Conflict of Interest. I also agree to report any potential future conflicts of interest to the Region 10 SUD Policy Oversight Board Chairperson prior to engaging in the action or activity.

Signature: *Date:*