



COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
APPLICATION FOR
THE COLORADO HIV/AIDS PREVENTION GRANT PROGRAM
ADVISORY COMMITTEE

Please also attach a current résumé

POSITION FOR WHICH YOU ARE APPLYING OR COULD REPRESENT (Please check all that apply)

- A representative of a statewide collaborative group that assists the department in the department's comprehensive plan for HIV and AIDS prevention (*4 possible positions from this category*);
- An individual recommended by the department's Minority Health Advisory Commission
- A recognized expert in HIV and AIDS Prevention and Education
- A representative of a clinic that receives moneys under Part C of the Federal Ryan White C.A.R.E. Act of 1990*

Name (Last, First, Middle)		County	
Home Address	City	State	Zip Code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Race (Optional) <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian	
Present Employer - Occupation	Business Phone No.	Home Phone No.	
Business Address		E-mail Address	

EDUCATION AND GENERAL QUALIFICATIONS

LEVEL	NAME OF SCHOOL	LOCATION	No. Years Attended	Did You Graduate?	Major Course(s) of Study
High School					
College					
Trade/Business/Correspondence					
Memberships in Organizations and Offices Held (Indicate if Past or Present)					
Board Appointments/ Memberships and Positions Held (Indicate if Past or Present)					
Volunteer Activities (Indicate if Past or Present)					
Special Skills and Qualifications					

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REFERENCES (List three persons, not related to you, who you have known for at least one year.)

NAME	ADDRESS	PHONE NO.

* If applying as a representative of a community-based organization or Part C clinic and are not a paid employee or board member, please also submit a letter signed by the agency's Executive Director and Board Chair concurring that you represent their agency.

Is there anything in your background that might be an embarrassment to the Executive Director or you if it were to become public?

YES NO (If YES, please explain in an attachment to this application)

I certify that the facts contained in this application are true and correct to the best of my knowledge. I authorize investigation of all statements contained herein and the references listed above to obtain any and all pertinent information, personal or otherwise. I release all parties for all liability for any damage that may result from furnishing such information.

I understand that the Colorado Open Records Act may require that certain information contained in this application be available for inspection by the general public.

SIGNATURE _____

Note: If you cannot sign the application electronically, e-mail with this field blank. It can be signed in person at a later date.

DATE _____

PLEASE E-MAIL COMPLETED FORM TO:

Mary Kay Myers - mary.myers@state.co.us

If necessary:

Fax to: 303-782-0904

OR

Mail to:
CHAPP Administrator and STI/HIV Planning Unit Coordinator
4300 Cherry Creek Drive S. Denver, CO 80246-1530