COLORADO
Department of Public Health & Environment

Women's Wellness Connection

Application for Breast and Cervical Cancer Screening Program Advisory Board

Please attach a current résumé

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

- ☐ A cardiovascular disease professional
- ☐ A cancer professional
- ☐ A public health professional
- ☐ Representative of rural or frontier interest in regard to breast and cervical cancer prevention and screening
- ☐ Consumer/ community member
- ☐ Other: _____

Name (Last, First, Middle)		Home Phone Number (including area code)	
Home Address	City	State	Zip Code
Date of Birth	Gender ☐ M ☐F	Race/ Ethnicity (Optional) ☐ Asian ☐ African American ☐ Native American ☐ Hispanic ☐ White ☐ Other:	
Present Employer		Present Occupation/ Title	
Business Phone Number (including area code)	E-mail Address		
Business Address	City	State	Zip Code

EDUCATION AND GENERAL QUALIFICATIONS (Please fill out using highlights from your résumé)

Level	Name of School	Location	Major Course(s) of Study
High School			
College/University			
Trade/Business/ Correspondence			
Memberships in Organizations and Offices Held (Indicate if Past or Present)			
Volunteer Activities (Indicate if Past or Present)			
Special Skills and Qualifications			

(Continued)

PLEASE INDICATE IN 100 WORDS OR LESS WHY YOU FEEL YOU WOULD BE AN IDEAL CANDIDATE FOR A BOARD POSITION

REFERENCES (List three persons, not related to you, whom you have known for at least one year and can speak to this application)

Name	Address	Phone Number

Is there anything in your background that might be an embarrassment to the Board 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 my application will be active unless I indicate different to the WWC section manager.

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 _____
(Please type your name; we will have you sign officially if selected)

DATE _____

RETURN COMPLETED FORM AND RÉSUMÉ TO:
Emily Kinsella, Women's Wellness Connection Section Manager
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-2698
Emily.kinsella@state.co.us | Phone: 303-692-2511 | Fax: 303-758-3268