BOARD OF COMMISSIONER: CONSUMER APPLICATION

Return completed application to:

Partnership HealthPlan of California
Attn: Maria Cabrera
4465 Business Center Drive
Fairfield, CA 94534

Instructions: Please Print. If you need additional room, please attach additional pages.

Name of Applicant: ____
Mailing Address: ________________________________ City: _______________________ Zip: ____________
Home Address: _________________________________ City: _______________________ Zip: ____________
Home Phone: ______________________ Work Phone: ______________________ Cell: ____________________
Email Address: _____________________________________

Relationship to PHC: Member Family member of PHC Member Former PHC Member

List past or present County appointments, as well as any other public service appointments, or elected positions held:

Dates Served

____ _______________
____ _______________
____ _______________

What experience or special knowledge can you bring to your area(s) of interest?

____
____
____

List any community organizations to which you belong:

Member Since

____ _______________
____ _______________
____ _______________
____ _______________

List any affiliation(s) you or your spouse has with public service agencies:

____
____
____
____

Signature: ____ Date: _______________________