



TEXAS DEPARTMENT OF STATE HEALTH SERVICES
APPLICATION FOR ADVISORY COMMITTEE/COUNCIL/
BOARD/PANEL APPOINTMENT

Name of Committee/Council/Board/Panel: Maternal Mortality and Morbidity Task Force
Initial appointment [X] Reappointment [ ]

Members of the Maternal Mortality and Morbidity Task Force

Please select the task force position for which you are applying.

- Physician specializing in psychiatry
Physician specializing in pathology
Medical examiner or coroner responsible for recording deaths

Please complete this application in a brief, yet informative manner. If questions are not applicable, enter "NA."

1. Name: Mr./Mrs./Miss/Ms./Dr./Rev. First Middle Last

2. Home Address:

Street or P.O. Box Apartment # City State Zip County
Home Phone Number Home Fax Number Home e-mail

3. Employer:

Name of Employer Current Position Title

4. Employment Address:

Street or P.O. Box City State Zip County
Business Phone Number Business Fax Number Business e-mail

5. Where you would like to receive future communications: [ ] Home [ ] Employment

6. Race/Ethnicity: [ ] American Indian/Alaskan [ ] Asian/Pacific Islander [ ] Black or African-American
[ ] Hispanic [ ] White [ ] Other:

7. Gender: [ ] Female [ ] Male

8. Education:

9. Professional License, Registration or Certification, if applicable:

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10. Relevant Experience (paid employment or volunteer): RÉSUMÉS WILL NOT BE CONSIDERED

11. Please list any current or former membership or board position(s) you have held with other organizations:

12. Why do you wish to serve in this capacity?

13. Personal and professional achievements (please include activities that address contributions you could make to the committee/council/board/panel):

14. Do you currently have any open complaints/disciplinary actions pending or have you ever been disciplined by any licensing board/professional or civic organization?

Yes, current complaint/disciplinary action pending       Yes, past complaint/disciplinary action       No

If yes, please explain:

15. Have you ever been convicted of a felony or a misdemeanor (excluding traffic violations)?       Yes       No

If yes, please explain:

16. Please submit two signed and dated letters of recommendation.

I ATTEST THAT ALL INFORMATION CONTAINED IN THIS DOCUMENT IS TRUE AND CORRECT.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See [www.dshs.state.tx.us](http://www.dshs.state.tx.us) for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004).

**PLEASE RETURN THIS FORM AND TWO LETTERS  
OF RECOMMENDATION BY EMAIL, MAIL OR FAX TO:**

**Email:** [MaternalHealth@DSHS.state.tx.us](mailto:MaternalHealth@DSHS.state.tx.us)

**Mail:** DSHS Office of Title V and Family Health  
P.O. Box 149347, MC 1922  
Austin, TX 78714-9347  
Attn: Catherine Gorham, Maternal & Child Health Program Coordinator

**Fax:** (512) 776-7658 Attn: Catherine Gorham

Please contact Catherine Gorham at (512) 776-2942 if you have questions.