



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 [] Reappointment []

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

- Physician specializing in obstetrics
Physician specializing in family practice
Certified nurse midwife
Registered nurse
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:

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 (Click to Sign) Date

PLEASE RETURN THIS FORM AND TWO SIGNED AND DATED LETTERS OF RECOMMENDATION BY EMAIL, MAIL OR FAX BY DECEMBER 08, 2014:

Email: 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: Beverly MacCarty, Maternal & Child Health Program Coordinator**

Fax: (512) 776-7658 Attn: Beverly MacCarty

Please contact Beverly MacCarty at (512) 776-6663 if you have questions.

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 for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004).