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

Name of Committee/Council/Board/Panel: **Newborn Screening Advisory Committee**

Initial appointment ☐ *Reappointment* ☐

Position Applying for: _____

(i.e., Consumer, Non-consumer, Public, Professional, etc.)

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

1. **Name:** _____
   First *Middle* *Last*

2. **Race/Ethnicity:** *(If applicable)* ☐ American Indian/Alaskan ☐ Asian/Pacific Islander ☐ Black or African-American ☐ Hispanic ☐ White ☐ Other:_____

3. **Gender:** ☐ Female ☐ Male

4. **Education:** _____

5. **Professional License, Registration or Certification, if applicable:** _____

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

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

8. **Why do you wish to serve in this capacity?** _____

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

19-5056-2 (rev 08/08)

10. 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: _____

_____

_____

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

If yes, please explain: _____

_____

_____

12. Home Address:

_____
Street or P.O. Box Apartment # City State Zip

_____ _____ _____
Home Phone Number Home Fax Number Home e-mail

13. Employment Address: _____ _____
Name of Employer Current Position Title

_____
Street or P.O. Box Suite # City State Zip

( ) _____ ( ) _____ _____
Business Phone Number Business Fax Number Business e-mail

14. Where you would like to receive future communications: ☐ Home ☐ Employment

15. 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

PLEASE RETURN THIS FORM TO:
David R. Martinez, Manager
Newborn Screening Unit
Specialized Health Services Section
Texas Department of State Health Services
P. O. Box 149347, Mail Code – 1918
Austin, Texas 78714-9347
Telephone: 512-776-2216
Fax: 512-776-7593

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).

For questions please contact Monica Molina by email at monica.molina@dshs.state.tx.us or by telephone at 512-776-3386.