# Texas Community Health Worker (CHW) Partnership (TX CHWP) Membership Application Form

## Mission

To support Texas' CHW workforce by engaging organizations, agencies, institutions, and individuals to work collaboratively to uphold certification standards, share training and professional development opportunities, and promote the integration of CHWs in healthcare systems and community-based programs.

## Membership Expectations

- There are no membership dues. However, members are strongly encouraged to:
- Attend TX CHWP meetings;
- Seek opportunities to collaborate with other partners to advance CHW training, certification and employment opportunities;
- Participate in a workgroup; and
- Share individual and/or organizational best practices and updates on activities.

## Instructions

Please complete this application and review the members' expectations.

**Name** (Last, First, Middle)**:**

**Credentials** (Check all that apply)

☐ CHW

☐ CHW Instructor

☐ Other (Specify):

**Job title** (CHW, CHWI, Project Manager, Advocacy Specialist, etc.):

**Email**:

**Select the option that best describes your current professional role.**

- [ ] Administrator / Program manager
- [ ] CHW
- [ ] CHW Instructor
- [ ] Consultant / Advisor
- [ ] Healthcare provider
- [ ] Professor / Academia
- [ ] Public health practitioner
- [ ] Researcher / Evaluator
- [ ] Social worker
- [ ] Other (Specify):

**How long have you been working on a CHW related role?**

- [ ] Less than 1 year
- [ ] 1–5 years
- [ ] 6–10 years
- [ ] 11–15 years
- [ ] 16–20 years
- [ ] 21+ years
- [ ] I don't work on a CHW related role

**Organization Information**

**Name of your primary organizational affiliation:**

**Address (Street):**

**City:**

**State:**

**Zip Code:**

*If joining as individual, enter your personal city, state, zip code.*

*We use this information to capture the geographic representation of our membership composition.*

**Which of these describes your organization? (Check all that apply)**

- ☐ Not applicable; I am joining as an individual.
- ☐ Local Health Department
- ☐ State Agency
- ☐ Federal Government
- ☐ Academic Institution
- ☐ Advocacy Group
- ☐ Business
- ☐ CHW Training Center
- ☐ Community Clinic / Federally Qualified Health Center
- ☐ Community-Based Organization
- ☐ Hospital/Health System
- ☐ Professional Society
- ☐ Other (Specify): _____

**Areas of Expertise (Check all that apply)**

- ☐ Advocacy
- ☐ Capacity Building
- ☐ Collaboration
- ☐ Communication and/or Marketing
- ☐ Community Development
- ☐ Cultural Competency
- ☐ Data Analysis
- ☐ Evaluation
- ☐ Government Relations
- ☐ Research
- ☐ Specific disease prevention or health promotion topic. Please describe.
- ☐ Strategic Planning and Implementation
- ☐ Training and Education
- ☐ Other (Specify): _____

_____

**Are you a member of the CHW Association?**

- ◯ Yes
- ◯ No

**If yes**, please specify: _____

**How did you learn about TX CHWP?**

- ☐ Conference/Meeting Presentation
- ☐ Friend/Colleague
- ☐ Newsletter/Email
- ☐ Search Engine
- ☐ Social Media
- ☐ Other (Specify): _____

**Submission Date:** _____

Thank you for your response! A Texas Department of State Health Services CHW Program will email you about the status of your membership application in 7 business days.