

**Kit Carson County Memorial Hospital
Home Health Agency and Caring Hands Hospice
Professional Advisory Committee Application**

Committee shall serve in an advisory capacity to insure safety and quality of care, treatment and/or services provided to the public by the Home Health Agency and Caring Hands Hospice.

General Information

Name (last): _____ First: _____ MI: _____

Address: _____ City/State/Zip: _____

Phone: _____ Birth Date: _____ E-mail: _____

Occupation: _____ Employer: _____

Education Level: _____

Professional Designation (Title and Discipline) as appropriate: _____

Community or Business Affiliation (Organization): _____

Education/Experience

Briefly describe what you do and why you would like to be a part of our Professional Advisory Committee: _____

List any prior contact with health care, either professionally, as a patient/consumer, or advocate for health care reform:

Community Representation

Flagler Vona/Seibert Stratton Bethune Burlington Idalia Cheyenne Wells

Individual, whether self or other, is aware of this nomination, is willing to serve for at least one term as a member of the committee and appears to have no conflict of interest that would preclude membership.

Yes No

Signature: _____ Date: _____

Self-nomination
 Nomination of other individual