



**P.O. Box 11949  
Fort Wayne, IN 46862-1949**

### **Board of Directors Application**

Name \_\_\_\_\_ Phone \_\_\_\_\_

E-mail \_\_\_\_\_

Address \_\_\_\_\_

Education \_\_\_\_\_

Employment Experience \_\_\_\_\_

Why are you interested in becoming a Board member? \_\_\_\_\_

What skills could you bring to the Neighborhood Health Clinics' Board?

Have you ever received any of the following services from Neighborhood Health Clinics?

- |  |                                       |                                       |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> WIC                             | <input type="checkbox"/> Medical Care | <input type="checkbox"/> Immunization |
| <input type="checkbox"/> Medical/Dental Referral Service | <input type="checkbox"/> Dental Care  | <input type="checkbox"/> Optometry    |

Do you have any relatives employed at Neighborhood Health Clinics?     Yes     No

Please list the names and phone numbers of 3 non-family references.

\_\_\_\_\_  
\_\_\_\_\_

**Please email completed board application to [info@nhci.org](mailto:info@nhci.org)**