BOARD COMMITMENT/CONFIDENTIALITY STATEMENTS

Before you complete an Application, we want you to know what would be expected of you as a Board member. Please read and initial each statement if you agree with the information in the statement:

(Initials)

|  |  |
| --- | --- |
|  | I agree with and am committed to the Family Health La Clinica Mission Statement:  *Our mission is to improve the health and well—being of all people in communities we serve.* |
|  | I agree with and am committed to the Family Health La Clinica Vision Statement:  *Healthy Individuals, Strong Families, Vibrant Communities.* |
|  | I agree with and am committed to demonstrate Family Health La Clinica’s Values:  *Equity, Honesty, Quality, Teamwork, Kindness, Innovation and Stewardship* |
|  | I agree to actively participate in Board meetings and to serve on at least one committee. |
|  | I understand that regular Board attendance is required and that it is extremely important to stay connected and involved in all Board activities. |
|  | I commit to serving approximately 2-6 hours per month. |
|  | I am willing to promote and support Family Health La Clinica. |
|  | I am a service user and/or would refer others to use FHLC healthcare services. |
|  | I agree not to discuss confidential information whether it is patient related, employee, business or management information where it may be overheard by others. I also agree not to talk about confidential information in public settings, even if the organization, patient or employee’s name is not mentioned. I understand that to do so may cause serious harm to FHLC, its patients and employees. |
|  | I agree to promptly report all violations of the confidentiality policy to the FHLC Board Chair or Chief Executive Officer. |
|  | I agree to the organization conducting a background/reference check as part of the application and interview process. |
|  | I have read and understand this commitment and confidentiality statement. |

*Thank you for taking the time to read and initial the statements above.*

**Board Application Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name:       Middle:       Last Name: | | | | | |
| Date of Birth:       Social Security Number\*\*: | | | | | |
| Address: | | | | | |
| City, State, Zip: | | | | | |
| Telephone/Cell:       Email: | | | | | |
| Current position/employer:  Is more than 10% of your annual income from the Health Care industry? | | | | | |
| How did you hear about the Family Health La Clinica Board? | | | | | |
| Are you a current user of Family Health La Clinica’s services?  Yes  No | | | | | |
| Why would you like to serve on the Family Health La Clinica Board? | | | | | |
| We are required to ask the following questions by our federal grant funding entity. Please review and check your experience with any that apply: | | | | | |
|  | **Age/Gender** |  | **Area of Expertise:** |  | **Racial/Ethnic Background:** |
|  | Male |  | Financial Management |  | Asian |
|  | Female |  | Healthcare |  | White |
|  | Other: |  | Human Resources |  | American Indian/Alaska Native |
|  | Prefer Not to Report |  | Legal |  | Hispanic or Latino |
|  |  |  | Planning |  | Black/African American |
|  |  |  | Business |  | Native Hawaiian |
|  | AGE |  | Faith-based |  | Other Pacific Islander |
|  | 65 and older |  | Public Sector |  | More Than One Race |
|  | 51 – 65 |  | Non Profit or Philanthropic |  | Prefer Not to Report |
|  | 36 – 50 |  | Marketing |  |  |
|  | 18 – 35 |  | Other: |  |  |
|  |  |  |  |  |  |
| **COVID-19 Compliance** - FHLC requires Board Members to be vaccinated against COVID-19, or hold a legally recognized exemption. Candidates who are offered a seat on the Board of Directors will be asked to provide proof of their vaccination status, which must meet minimum business requirements. All religious, medical, or other legally recognized exemptions regarding vaccination status will be considered. Do you agree to comply with this standard?  Yes  No | | | | | |
|  | | | | | |
| **Medicare Compliance** - Within the last 10 years, were you convicted, plead guilty or no contest, or consent to a pretrial diversion to a felony or have you been excluded from participating in the Medicaid or Medicare program?  Yes  No | | | | | |
| What do you believe will be your major contribution to the Family Health La Clinica Board? | | | | | |
|  | | | | | |

Have you had any other current or past Board involvement:  Yes  No

(If yes, please list them below.)

|  |  |  |
| --- | --- | --- |
| Name of Organization: | Position Held: | Years: |
|  |  |  |

|  |
| --- |
| Please share a brief summary of your community and work experiences: |

Please list 2 personal or professional references:

|  |  |
| --- | --- |
| Name: | Contact Number: |
|  |  |
|  |  |

Are you related to any of the current Board of Directors or staff of Family Health La Clinica?  Yes  No

If yes, who? \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By submitting this application, I agree and acknowledge that if selected as a Board of Directors member for Family Health La Clinica, I will be committed to accomplish the organization’s Mission, Vision, Values and Strategic Plan.

Signature: /s/     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_Click or tap to enter a date.

Please return your application to:

Laura Waldvogel Email: [laura.waldvogel@famhealth.com](mailto:laura.waldvogel@famhealth.com)

or

Family Health La Clinica

Attn: Laura Waldvogel, CEO

400 S Townline Road / P.O. Box 1440

Wautoma, WI 54982