2016 APPLICATION FOR NOMINATION TO SERVE ON THE BOARD OF TRUSTEES OF THE PUBLIC HEALTH TRUST OF MIAMI-DADE COUNTY

Mission

To provide a single high standard of health care, education and research

To improve patient and customer satisfaction, enhance professional fulfillment and provide public service

Chapter 25A of the Miami-Dade County Code states that the governing body of the Trust shall consist of 7 voting members, none of whom shall be employees of the Trust. Board members are appointed to the Trust during the annual appointment process or through a special convening of the Nominating Council. The membership of the Board of Trustees should be representative of the community at large and should reflect the racial, gender, ethnic and disabled make-up of the community. Candidates will be screened for any potential conflict of interest with the responsibilities of a Board member.

Completed applications and resumes can be mailed or hand delivered to the address below by **February 9, 2016 at 4:00 pm.** Emails or facsimiles of the application and resume will be accepted and can be sent to **clerkbcc@miamidade.gov** or faxed to 305-375-2484. It is the responsibility of the applicant to ensure electronic receipt of the application and resume by calling the Clerk of the Board at 305-375-1652.

Clerk of the Board of County Commissioners
ATTENTION: Christopher Agrippa
111 NW 1st Street, Suite 17-202
Miami, Florida 33128
(305)375-1652

ATTENTION APPLICANTS: BACKGROUND CHECKS WILL BE PERFORMED ON ALL APPLICANTS SELECTED FOR AN INTERVIEW. IF SELECTED, TRUSTEES WILL BE REQUIRED TO SUBMIT FINANCIAL DISCLOSURE FORMS.

Candidate for Nomination to Serve on the Board of Trustees
Public Health Trust of Miami-Dade County

Jackson Health System

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Biographical Profile

Name: _____
Last First Middle

Employer:_____

Title/Occupation:_____

Business Type: _____

Business Address:_____

Business Telephone: _____ Fax: _____

Email Address: _____

Home Address: _____

Home Telephone: _____

Date of Birth: _____ Length of Residence in Miami-Dade County: _____

PLEASE CHECK APPROPRIATE INFORMATION LISTED BELOW *(Optional)*

- ☐ Male
- ☐ Female
- ☐ White Non-Hispanic
- ☐ Black Non-Hispanic
- ☐ Hispanic
- ☐ Asian or Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ Haitian American

EDUCATION:

School/City/Major/Degree:

_____

_____

_____

Previous Employment and Professional Background:

Business Name	Position	Years

EXPERIENCE AND/OR QUALIFICATIONS:

Describe how your past experience and/or qualifications would benefit the Public Health Trust:

_____

_____

_____

_____

ORGANIZATIONS AND ACTIVITIES:

List community, civic, professional and other organizations of which you are a member:

Organization	Position Held
_____	_____
_____	_____
_____	_____

List any Public Office held (Elected or Appointed):

Office	Date
_____	_____
_____	_____

Affiliations with hospitals, nursing homes or other health related institutions:

_____

_____

_____

Activities reflecting community interest:

_____

_____

_____

List all potential conflicts of interest, including potential conflicts arising from your relationships or the relationships of any of your family members in the healthcare industry:

_____

_____

_____

References - Persons acquainted with candidate's activities/experience:

Name	Title	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe the goals and objectives you will seek to accomplish if you are selected as a Trustee:

_____

_____

_____

_____

_____

_____

I, (candidate's name) _____, Citizen of the United States, a duly qualified elector of Miami-Dade County, and not affiliated with the Public Health Trust of Miami-Dade County or its subordinate agencies or institutions, would, if appointed, be willing and able to discharge the responsibilities and functions of Trustee. I declare that, if selected while currently serving on another official County board, I will resign from my other County responsibilities.

_____ _____

Date **Candidate's Signature**

Nominated by (if not self):

_____ _____

Name **Telephone**

_____ _____ _____

City **State** **Zip Code**