Board of Directors Application

Upstate Family Health Center, Inc.

CONTACT INFORMATION	
Name:	
Address:	
Phone Number:	
County of Residence :	Email Address:
Are you a patient of Upstate Family Health Center? ❑ Yes ❑ No	If no, would you consider being a patient? ❑ Yes ❑ No

PROVIDE A LIST OF OTHER BOARDS THAT YOU HAVE BEEN A MEMBER OF AND YOUR TENURE;	
Organization Name	Board Tenure Dates

PROVIDE 1 OR 2 SIGNIFICANT CONTRIBUTIONS YOU HAVE MADE TO ONE OR MORE THESE BOARDS.	
Organization Name	Your Contributions

WHAT INTERESTS YOU ABOUT SERVING ON THE UFHC BOARD?

WHAT EXPERIENCE, KNOWLEDGE AND SKILLS YOU POSSESS DO YOU FEEL THAT UFHC CAN BENEFIT FROM?

DEMOGRAPHIC INFORMATION

As a Federally Qualified Health Center (FQHC), we are able to offer services to all our patients, including the underserved, as a result of our Federal designation. As a FQHC, we are required to gather, on a yearly basis, statistics about the Board members and patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

Race
- ❑ Caucasian/White
- ❑ Asian
- ❑ Black/African American
- ❑ American Indian/Alaska Native
- ❑ Pacific Islander
- ❑ Native Hawaiian
- ❑ More than one
- ❑ Choose not to disclose

Ethnicity
- ❑ Latino/Hispanic
- ❑ Not Latino/Hispanic
- ❑ Choose not to disclose

What is your sexual orientation?
- ❑ Bi-Sexual
- ❑ Heterosexual
- ❑ Homosexual
- ❑ Choose not to disclose
- ❑ Prefer to describe below:

Gender Identity
- ❑ Male
- ❑ Female
- ❑ Non-Binary
- ❑ Choose not to disclose
- ❑ Cisgender
- ❑ Transgender
- ❑ Prefer to self-describe below: _____

Age
❑ Under 35 ❑ 35-44 years ❑ 45-54 years ❑ 55-64 years ❑ 65 or older ❑ Choose not to disclose

Annual Household Income
❑ <$10,000 ❑ $10-$20,999 ❑ $21-$30,999 ❑ $31-$40,999 ❑$41-$50,999 ❑ $51-$60,999 ❑ over $70,000

DISABILITY STATUS

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. Disabilities include, but are not limited to:

Autism/ Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AID/ Blind or low vision/Cancer/Cardiovascular or heart disease/Celiac disease/Cerebral palsy/Deaf or hard of hearing/Depression or anxiety/Diabetes/Epilepsy/Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome/Intellectual disability/Missing limbs or partially missing limbs/Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)/Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

❑ Yes, I have a Disability, or Have a History/Record of Having a Disability

❑ No, I have a Disability, or Have a History/Record of Having a Disability

❑ Choose not to disclose