TIDES TRANSGENDER HEALTH ACCESS INITIATIVE
COMMUNITY ADVISORY PANEL (CAP)

APPLICATION FORM

Due by February 25th, 2009

Preferred Name________________________ ________________________ ______
Last First MI

Contact Information

____
Number and Street

______________________________________ _________ ________ ________
City State Zip

____ _____________________________
Email Address Phone Number

Optional Information:

Age: _________ Gender: ________________ Preferred Pronoun: ____________

Ethnicity/Race: ________________________________

Do you have any special needs that require accommodation?

No Yes, specify: ___________________________

By signing below, I allow LMHS to contact me regarding the Community Advisory Panel (CAP); I understand the qualifications and roles as a member of CAP. I understand that this information will be kept confidential.

____ _______/_______/_______
Signature **Date**

____
Name (Printed)

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In a few words please answer the following questions below. If more room is needed, please use the back side of this page.

Explain your involvement in transgender health care.

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Why do you want to join Transgender Health Access Initiative Community Advisory Panel (CAP)?

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What would you like to contribute to CAP? Please feel free to note any special skills or abilities you think are relevant.

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Please submit completed applications to ATTN: Kara Nostrand either by mail or fax
1748 Market St. Suite 201, San Francisco CA 94103, Fax: (415) 252-7512
For more information contact Kara Nostrand at (415) 565-7667 ext. 318