



**BOARD OF DIRECTORS
MEMBERSHIP APPLICATION**

Name: _____ *Social Security Number _____
(Please print)

Address: _____

City: _____ State: _____ Zip Code: _____

*State of Birth: _____ Country of Birth: _____

Mailing Address: _____ Birthday: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

E-mail address: _____ Cell Phone: _____

I prefer to be called at: Home Work Cell

Age: (Please check one)
18 to 30 31 to 40 41 to 50 51 to 60 61 or above

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unreported/Declined to Report

Male Female Unreported/Declined to Report Transgender

Race: (Please check one)
Black/African American American Indian or Alaska Native White Asian
Native Hawaiian or Other Pacific Islander More Than One Race
Unreported/Declined to Report

Employed By: _____

Job Title: _____

Professional Activities: _____

Volunteer Activities: _____

Medicare/Medicaid requires all board members to be listed on our application to accept these insurance programs. Your social security number is mandatory for this process. MedNorth is also required to confirm that you are not excluded from working with federally funded programs (exclusions.oig.hhs.gov).



**BOARD OF DIRECTORS
MEMBERSHIP APPLICATION**

Federal regulations require that fifty one percent (51%) of MedNorth Health Center’s Board of Directors be users of the health center. Are you a user of the health center? Yes No

Have you used the health center within the past twelve (12) months? Yes No

Is MedNorth Health Center your principal place for medical care? Yes No

If you are not a current patient, do you plan to use the health center for your medical care?
Yes No

Why do you wish to serve on the board? _____

What do you feel are your qualifications for serving on the board? _____

What areas of concern would you like to see the board address? _____

If elected to serve on the Board of Directors of MedNorth Health Center, I agree not to disclose or use confidential information relating to the Corporation for the personal business or profit or advantage of myself, my family, or others.

Any information concerning the business or affairs of MedNorth Health Center, its suppliers, dealers, patients, employees or personnel associated with MedNorth Health Center is confidential and restricted. If the board member is not sure if information is subject to this confidentiality duty, refer inquiries to the Chief Executive Officer.

All information related to patients is confidential and cannot be the subject of discussion at any time except for purposes of diagnosis and treatment. Breach of confidentiality will result in immediate discharge from the Board of Directors.

I understand and agree to the above statement:

Name: _____ Date: _____
Signature

Medicare/Medicaid requires all board members to be listed on our application to accept these insurance programs. Your social security number is mandatory for this process. MedNorth is also required to confirm that you are not excluded from working with federally funded programs (exclusions.oig.hhs.gov).