BOARD OF COMMISSIONER: CONSUMER APPLICATION

Submit completed form:
Online by clicking submit below or
By Mailing to:
Partnership HealthPlan of California
Attn: Araceli Gutierrez
4665 Business Center Drive Fairfield, CA 94534

Instructions: Please complete all sections, use N/A if a section does not apply to you. If you need additional room, please add additional pages.

Name of Applicant: _____

Mailing Address: _____ City: _____ Zip: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____

Relationship to PHC:

☐ Member
PHC ID #_____

☐ Family member or representative of PHC Member
PHC Member Name _____
PHC ID # _____ Relationship to member _____

List past or present County appointments, as well as any other public service appointments, or elected positions held:

	Dates Served
_____	_____
_____	_____
_____	_____

What experience or special knowledge can you bring to your area(s) of interest?

_____

_____

_____

List any community organizations to which you belong:

	Member Since
_____	_____
_____	_____
_____	_____
_____	_____

List any affiliation(s) you or your spouse has with public service agencies:

_____

_____

_____

_____

Signature: _____ Date: _____

SUBMIT