Mount Sinai

MOUNT SINAI HOSPITAL
COMMUNITY ADVISORY BOARD
APPLICATION FOR CONSUMER MEMBERSHIP

APPLICANT INFORMATION		
Name:		
Current address:		
City:	State:	ZIP Code:
Home #:	Cell #:	Email:

COMMUNITY AFFILIATION		
Please indicate if you live or work in zip codes 10029 or 10035 and/or are designated to represent community agencies therein:		
Yes: ☐	No: ☐	
Work Address or Community Agency:		
Best Point of Contact:	Phone:	

HEALTH CARE (OPTIONAL)		
Do you receive your health care from a physician affiliated with Mount Sinai or from the Mount Sinai Hospital?		
Yes: ☐	No: ☐	
If yes, please specify where and from whom:		
When did you last receive services from a Mount Sinai physician or from the Mount Sinai Hospital? Please specify date:		

EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		How long?
City:	State:	ZIP Code:
Phone:	E-mail:	
Title:		

EDUCATION	
Name of High School/College/University:	
Degree(s) Earned:	Field:
Honors:	Year Graduated:
Name of College/University:	
Degree(s) Earned:	Field:
Honors:	Year Graduated:
Name of College/University:	
Degree(s) Earned:	Field:
Honors:	Year Graduated:

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DISCLOSURES

Do you hold a fiduciary position with or have a fiduciary interest in any organization (or associations composed of such organizations) engaged in the provision of health care or in such (this includes serving on the governing body of any such)?

□ **No or Not Applicable**
□ **Yes. Please explain:**

_____

Do you or your spouse receive more than 1/10 of your gross annual income from any of the following?

- Fees or other compensation for research into or instructions in the provision of health.
- Organizations (or associations of such organizations) engaged in the provision of health care or in such research or instruction.
- Producing or supplying drugs or other articles for individuals of organizations for use in the provision of or in research into or instruction in the provision of health care.

□ **No or Not Applicable**
□ **Yes. Please explain:**

_____

Are you engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits? (This does not apply to negotiating or arranging such a contract for an organization by which you are employed or which you own.)

□ **No or Not Applicable**
□ **Yes. Please explain:**

_____

Is any member of your immediate family a physician, dentist, nurse, a health worker or administrator?
□ **No.**
□ **Yes. Describe your relationship, and with which institution is he/she affiliated?**

_____

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WRITTEN RESPONSES

Describe your interest in healthcare. Do you have involvement or experience in healthcare or health-related activities either now or in the past?

Please list any organizations of which you are currently a member. Please indicate years of service.

- ❖
- ❖
- ❖
- ❖

Please list any organizations in which you hold a position on a board of directors, steering committee, or any executive position. Include the number of years in each position.

- ❖
- ❖
- ❖
- ❖

The vision of the Mount Sinai Health System is "*to continue to grow and challenge convention through our pioneering spirit, scientific advancements, forward-thinking leadership, and collaborative approach to providing exceptional patient care.*" Clinical and non-clinical staff, volunteers, and board members share the system's core values; we are **Collaborative**, **Creative**, **Agile**, **Empathic**, and **Passionate**. Describe your vision for the Mount Sinai Hospital Community Advisory Board, and how will you use your talents and the values of the health system to guide that vision?

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REFERENCES *(PLEASE PROVIDE A MINIMUM OF TWO)*			
Name:	Relationship to you:	Phone:	Email:

SIGNATURES

I certify that this application is submitted in good faith and that the information provided by me is true and correct, to the best of my knowledge. I recognize that my attendance at the monthly meetings of the Mount Sinai Hospital Community Advisory Board is compulsory, unless previously excused for a reason acceptable to the Chair. I acknowledge that any information I have provided will be verified by the staff of the Mount Sinai Health System. I understand that my application may be denied if I do not meet the requirements of Consumer Membership, or if my qualifications do not match the current needs of the board.

Signature of applicant:	Date: