Marion County Mental Health Advisory Committee  
Supplemental Questionnaire  
*Please complete this supplemental questionnaire and submit with your completed Advisory Board Application to be considered for a position on the Mental Health Advisory Committee (MHAC). In accordance with ORS 430.075(1) twenty percent of the committee shall be consumers, with representation balanced by age.*

Name: Click or tap here to enter text. Age: Click or tap here to enter text.

Ethnicity: Click or tap here to enter text. Race: Click or tap here to enter text.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. In what part of Marion County do you live? (Please fill in town/city) | | | | | | | |
|  |  | | | | | | |
|  | Canyon (Stayton, Mill City, Detroit: Click or tap here to enter text. | | | | | | |
|  | North Marion (Woodburn, Mt. Angel, Silverton): Click or tap here to enter text. | | | | | | |
|  | South Marion (Jefferson, Turner): Click or tap here to enter text. | | | | | | |
|  | Salem/Keizer: Click or tap here to enter text. | | | | | | |
|  | Other: Click or tap here to enter text. | | | | | | |
| 1. I currently work or have worked in the following fields *(Please select all that apply):* | | | | | | | |
| Field | | Current | Past | Was this in Marion County? | | | Comments |
| Yes | | No |
| Mental health care | |  |  |  | |  | Click or tap here to enter text. |
| Physical health care | |  |  |  | |  | Click or tap here to enter text. |
| Services to persons with disabilities | |  |  |  | |  | Click or tap here to enter text. |
| Dental health care | |  |  |  | |  | Click or tap here to enter text. |
| Alcohol & Drug treatment | |  |  |  | |  | Click or tap here to enter text. |
| Public health services | |  |  |  | |  | Click or tap here to enter text. |
| Education K-12 | |  |  |  | |  | Click or tap here to enter text. |
| Education Post-Secondary | |  |  |  | |  | Click or tap here to enter text. |
| 1. I am a member of AND have an interest in representing the following group(s):   *(Please select all that apply)* | | | | | | | |
|  | | | | |  | | |
| Senior (65+) | | | | | 16-22 years old | | |
| Current or former user of mental health services (self or family) | | | | | Current or former user of substance abuse services (self or family) | | |
| Persons with disabilities (self or family) | | | | | Under-represented racial or ethnic group. Please specify: Click or tap here to enter text. | | |
| Other: Click or tap here to enter text. | | | | |
|  | | | | | | | |
| 1. How did you learn about the Mental Health Advisory Committee vacancy? | | | | | | | |
| Click or tap here to enter text. | | | | | | | |
| 1. What is your primary area of interest? | | | | | | | |
| Click or tap here to enter text. | | | | | | | |
| 1. Do you know of any potential conflicts you may have if you are selected for appointment to MHAC? | | | | | | | |
| Yes  No  If yes, how do you see resolving the conflict? Click or tap here to enter text. | | | | | | | |

**Sign a hard copy:**

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Or -

**Sign electronically:**

By typing my name in the text box below, I confirm all the information on this questionnaire is true to the best of my knowledge.

**Click or tap here to enter text.**

**Thank you!**