The Florida Department of Health, HIV/AIDS and Hepatitis Program is committed to recruiting members to serve on advisory groups, committees and other ad hoc committees/groups to assist in addressing HIV/AIDS policies, programs, issues and concerns. These committees/groups are discretionary bodies formed by the HIV/AIDS and Prevention Program to represent people living with HIV/AIDS and individuals at high and increased risk. These committees/groups will also serve affected communities, community-based organizations and AIDS service organizations. The HIV/AIDS and Hepatitis Program reserves the right to remove an individual from a committee/group due to lack of participation, attendance or behavior. Each individual selected will serve a two-year term. Members are expected to attend meetings, conference calls and maintain an ongoing engagement with organizations and individuals from the group they represent. The individual participation on the committee/group will be re-determined after the completion of his/her second term.

The primary responsibilities of the committee/group is defined in the Roles and Responsibilities document available on the HIV/AIDS and Hepatitis Program website http://www.doh.state.fl.us/disease_ctrl/aids/care/CAG_consum_advis_group.html. Individuals interested in being considered for membership should complete and mail or fax the attached form to:

Florida Department of Health
HIV/AIDS and Hepatitis Program
4052 Bald Cypress Way, Bin A-09
Tallahassee, Florida 32399-1715

Attention: Bruce Campbell
Consumer Advisory Group Liaison
or
Fax to: (850) 245-4920

For additional information, please contact Bruce Campbell at (850) 245-4444 ext. 2540.
HIV/AIDS and Hepatitis Program
Membership Application Form
Consumer Advisory Group

Name: ____________________________  ____________________________  ____________________________

First  Middle  Last

Title (if any): ____________________________

Address: ____________________________

Contact Information:
Home Phone: ____________________________  Work Phone: ____________________________
Cell Phone: ____________________________  Other: ____________________________

Email Address: ____________________________

Optional Information:
Sex:  ☐ Female  ☐ Male  ☐ Transgender  Age: ________ years

Sexual Identity:  ☐ Homosexual  ☐ Bisexual  ☐ Heterosexual  ☐ Other ________

Sexual Orientation:  ☐ Male Sex Partners Only  ☐ Both Male and Female Sex Partners
☐ Female Sex Partners Only  ☐ Other __________________

Race/Ethnicity: (Check all that apply)
☐ American Indian/Alaskan Native
☐ Asian/Pacific Islander
☐ Black/African American
☐ Haitian (Any Race)
☐ Hispanic (Any Race)
☐ White/Caucasian
☐ Other/Unknown ____________________________
Category of Representation (check all that apply to you):

- Individual living with HIV or AIDS
- Affected communities: including populations hard-hit with HIV and historically underserved groups
- AIDS service organization and/or community-based organization
- Health care provider
- Social service provider
- Mental health provider
- State or local government: Specify:
- Former Prisoner and/or their representative
- Part A, B, C, or D grantee
- Non-elected community leader
- Other: Specify:

Please answer the following questions as completely as possible (use the back a separate page if necessary):

What particular skills or expertise would you bring to the committee/group?

Have you had any experience participating in community planning, health planning, or other similar group planning processes? If so, please describe.

Why are you interested in becoming a member of the Consumer Advisory Group?
In the HIV/AIDS Program, HIV prevention and care are top priorities. Please describe what components you feel need to be in place in a community to prevent HIV and to provide care to those individuals who are infected?

The Consumer Advisory Group is in agreement that disclose of their HIV status openly and available for public engagements. Are you willing to be in the public’s eye with your HIV status?

Is there any additional information you would like us to consider when reviewing your application?

Signature

By signing this Application Form, I certify that all information contained herein is true and accurate to the best of my understanding. I also certify that I have read and understand the membership requirements outlined on Page 1 of this form and the Roles and Responsibilities of a CAG member. If accepted for membership, I will fulfill all membership requirements as put forth by the HIV/AIDS and Hepatitis Program and the Consumer Advisory Group.

Signature:___________________________________________________________

Signature Required

Date Submitted:_______________________________________________________

Additional materials may also be attached and submitted for consideration.