

**Florida HIV/AIDS Comprehensive Planning Network  
Member/Professional Information Disclosure Form**

All nominees must complete the Nominee/Member Disclosure Form. The purpose of this form is to provide the State Health Office with information about planning group members. The information is used to ensure compliance with the guidelines of parity, inclusion, and representation as defined and required by the Centers for Disease Control and Prevention (CDC).

**NAME:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**AGE:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **RACE/ETHNICITY:** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_ **BUSINESS ADDRESS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**TELEPHONE (HOME)** \_\_\_\_\_ **E-Mail Address:** \_\_\_\_\_  
**(BUSINESS)** \_\_\_\_\_ **(FAX)** \_\_\_\_\_  
**(SUNCOM)** \_\_\_\_\_ **(SUNCOM FAX)** \_\_\_\_\_

**Please list any HIV/AIDS Professional Associations/Organizations that you are affiliated with.**

\_\_\_\_\_  
 \_\_\_\_\_

**Issues/Groups Represented:** (Please check all that apply)

Substance Abuse	_____	Bisexual	_____
HIV+/PWA	_____	Youth	_____
Partners of HIV+/PWA	_____	People Who Barter Sex	_____
Men Who Have Sex with Men	_____	Prisoners/Inmates	_____
Lesbian	_____	Other (Please specify)	_____

<b>AFFILIATIONS:</b> (Check all that apply)	<b>FOR DEPARTMENT USE ONLY:</b>
Partnership _____	Community _____
Consortium(tia) _____	Ryan White _____
CBO/ASO _____	Public Health _____
	At-Large (area of representation) _____

Disclosure of information contained on this form is prohibited unless authorized by the nominee in writing. Please indicate by signing below your approval for the department and/or the Florida HIV/AIDS Comprehensive Planning Network to disclose this information as needed for issues directly related to community planning. This information will only be used in aggregate forms and will not be linked to FCPN members by individual identifiers.

Signature \_\_\_\_\_

Date \_\_\_\_\_