Florida Department of Health

Florida Preventive Health & Health Services Block Grant Advisory Committee

As a requirement of federal regulations for the Preventive Health and Health Services Block Grant (PHHSBG), the Florida Department of Health (Department) must convene an advisory committee at least twice annually to make recommendations regarding funding allocations; assessments of public health and related activities; and relevant programs or entities that should be involved in carrying out recommended activities. The PHHSBG currently funds chronic disease prevention activities associated with *Community Health Assessments*, *Community Health Improvement Plans*, *Healthiest Weight Florida* activities, the Dental Health Fluoridation Program, and the Sexual Violence Prevention Program. In addition, the committee is expected to mobilize individuals, communities, healthcare providers, healthcare payers, and policymakers to use prevention strategies in optimizing the health and well-being of Floridians across the lifespan.

Individuals will be appointed to the Committee by the State Surgeon General and will serve staggered four year terms. Members are expected to attend meetings and conference calls and maintain an on-going engagement with organizations and individuals from the group they represent.

Individuals interested in being considered for membership should complete and mail, fax, or e-mail the attached form to:

Florida Department of Health
Bureau of Chronic Disease Prevention
4052 Bald Cypress Way, Bin A-18
Tallahassee, Florida 32399-1744
Phone: (850) 245-4330
Fax: (850) 414-6625
Email: Calandra.Portalatin@flhealth.gov

(Please print and sign. Submit by mail, fax, or e-mail (scan signed copies). Electronic signatures are not accepted).

For additional information, please contact Calandra Portalatin (850) 245-4444, ext. 3797.

Florida Preventive Health & Health Services Block Grant Advisory Committee Membership Application

Name:			
	First	*Middle Initial*	*Last*

***Gender:** ☐ Female ☐ Male

***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_____

Certificates/Degrees held (if any):

Position Title (if any):

Please provide information on the agency that you will be representing within the Committee:

Agency Address:

City/State: **County:**

Contact Information:

Agency Phone:	**Fax:**
Cell Phone:	**Other:**

Email Address:

*** This information will be used to provide demographic statistics and is not requested for the purpose of discriminating on any basis.**

Category of Interest/Expertise (check all that apply to you):

☐ Advocacy group	☐ Dental Professional Association	☐ Research organization
☐ Business, corporation or industry	☐ Department of Health	☐ Schools of Public Health
☐ College and/or university	☐ Faith-based organization	☐ Sexual Violence Prevention/Intervention
☐ Community-based organization/coalition	☐ Hospital or health system	☐ State or local government
☐ Community Health Center	☐ Managed care organization	☐ Substance abuse or Mental Health organization
☐ Community resident	☐ Medical society or organization	☐ Tobacco control organization
☐ Community Planning	☐ Minority-related organization	☐ Youth serving organization
☐ County and/or local health department	☐ Public and/or private school (K-12)	☐ Other (specify): _____

What particular skills or expertise would you bring to the committee/group? (Check all that Apply)

☐ Advocacy	☐ Policy Development
☐ Community Assessment	☐ Program Evaluation/Monitoring
☐ Epidemiology	☐ Strategic Planning
☐ Health Education	☐ Surveillance
☐ Partnership/Capacity Building	☐ Other (specify):_____

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

Have you participated in community planning (i.e., needs assessments), health planning, or other similar group planning processes? If so, please describe.

Please describe, if any, your public health and/or chronic disease experience?

Why are you interested in becoming a member of the Florida Preventive Health Advisory Committee?

Are there any conflicts of interest that may prohibit you from serving as a member of Florida Preventive Health Advisory Committee? ☐ Yes ☐ No

If yes, please explain:

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

By signing this application, 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 expectations, guidelines, and if accepted for membership, will fulfill all membership expectations as put forth by this council.

Signature:_____

Original Signature Required

Date Submitted:_____

If possible, please attach a current bio to this Membership Form for our files. Additional materials may also be attached and submitted for consideration.