

Trauma System Advisory Board Appointment Application

This form is for appointment qualification and article information for appointees. Please attach a biography or resume to this form if available.

Personal Information

Name (Please type or print last name, first name and middle initial)

Name _____

Legal Residence Street _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Business Phone _____

E-Mail Address _____ Occupation _____

Education

Educational Institutions Attended Excluding High School:

School Name	Location	Dates	Majors/Degree
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employment

Statute requires some board appointees meet specific employment criteria. List employment beginning with most recent experiences. A resume or additional information is optional.

Employer	Location	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you a(n): First Responder EMT EMT-I Paramedic Physicians Assistant Nurse Practitioner Physician Other _____

Please Complete Reverse Side of Form

Additional Information

Please list additional information including honors, awards, organizations, associations, boards or commissions you serve(d) on.

Areas of Interest (Limit Two)

- Out-of-Hospital Hospital Rehabilitation Designation Vehicles/Equipment Triage/Transport Public Information
 Prevention Pediatrics Burns Training Consumer Data Collection Quality Assurance

IMPORTANT:

Check all board appointments for which you are applying. If willing to serve on either statewide or regional boards, please indicate by 1 and 2, the order of preference.

_____ Statewide Trauma Advisory Board Member

_____ Statewide Medical Director

_____ Regional Advisory Board Member (Please indicate Region 1, 2, 3 or 4)

_____ Regional Medical Director (Please indicate Region 1, 2, 3 or 4)

List references including names, addresses, and phones numbers of a minimum of three individuals unrelated to you.

As a citizen of the United States and a resident of the State of Nebraska, I will accept appointment if selected by the Director of Public Health and if appointed, I pledge my best efforts as an appointee.

Name (Please Print)

Signature

Address

Date

City

State

Zip

Submit applications to: Sherri Wren, EMS/Trauma Program
Nebraska Department of Health and Human Services
P.O. Box 95026, Lincoln, NE 68509-5026
E-mail: sherri.wren@nebraska.gov
FAX: (402) 471-1890
<http://dhhs.ne.gov/ems>