

Application Form

PAIMI Advisory Council (Protection and Advocacy for Persons with Mental Illness)

If you have questions, contact Enid Gonzalez at enid.gonzalez@disabilityrightsn.org or by calling 919-856-2195 or 877-235-4210. On request, the application is available in alternative format.

(First Name) _____ (Last Name) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ E-MAIL: _____

SEX: _____ MALE _____ FEMALE

AGE RANGE: _____ 18 – 39 _____ 40 – 59 _____ 60 and over

I am a North Carolina resident and live in _____ County. (mandatory)

Please check all categories below that apply to you:

- I am a person who has received or is receiving mental health services.
- I am a family member of a person who has received or is receiving mental health services.
If a family member, please state your relationship: _____
- I am an attorney.
- I am a mental health professional.
- I am a provider of mental health services.
- I am a person from the public who is knowledgeable about mental illness, the advocacy needs of people with mental illness and have demonstrated a substantial commitment to improving mental health services.

My race/ethnicity is:

Asian _____ Black, not of Hispanic/Latino origin _____
Hispanic/Latino _____ Pacific Islander _____
North American Indian or Alaskan Native _____
White, not of Hispanic/Latino origin _____

5. Describe your involvement on committees, organizations, conferences/trainings, etc. that address mental health issues. Please include the names of committees, organizations, etc.

6. Describe your educational/work experience.

7. Provide the name and telephone number of two references who are knowledgeable about your advocacy efforts/involvement regarding mental health issues.

The PAIMI Advisory Council may request an interview which can be conducted either by teleconference call or in person. If selected to serve on the PAIMI Advisory Council, I agree to participate in the PAIMI Advisory Council meetings and my participation may be by teleconference calls. I understand that if I am unable to attend official PAIMI Advisory Council meetings on a regular basis, that I may be removed. I also understand that I will be reimbursed for my travel costs in order to participate in the PAIMI Advisory Council activities.

Signature

Date

You may submit this application to:
PAIMI AC Applications
Disability Rights North Carolina
Attn: Enid Gonzalez
3724 National Drive, Suite 100
Raleigh, NC 27612

If you wish to send it electronically, detach this document and save to your computer. Then send to Disability Rights NC as an attachment to your e-mail. Send email to enid.gonzalez@disabilityrightsn.org.