

**Oregon Deaf and Hard of Hearing Services Program
APPLICATION FOR MEMBERSHIP ON THE
ODHHS ADVISORY COMMITTEE**

This form can be obtained electronically or by calling the Department of Health Services (DHS), ODHHS at 971-301-1618 Voice/Text

Please return your completed application along with your resume to: Theresa Powell, Advocacy and Development Unit, Oregon Deaf and Hard of Hearing Services, 500 Summer St NE, E-02, Salem, OR 97301.

Or email : Theresa.A.Powell@state.or.us

APPLICANT INFORMATION

APPLICANT NAME	
MAILING ADDRESS	
MAILING CITY, STATE, AND ZIP CODE	COUNTY
EMAIL ADDRESS	
(AREA CODE) TELEPHONE #	VIDEOPHONE NUMBER OR IP ADDRESS

COMMUNICATION AND ACCOMMODATION

Hearing loss (check one)	Communication preference (check all that apply)	
<input type="checkbox"/> Deaf	<input type="checkbox"/> American Sign Language (ASL)	<input type="checkbox"/> Tactile (Deaf-Blind)
<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Cochlear Implant User	<input type="checkbox"/> Oral/Lip-reading
<input type="checkbox"/> Deaf-Blind	<input type="checkbox"/> Low Vision(Deaf-Blind)	<input type="checkbox"/> Spoken Language
<input type="checkbox"/> Hearing/Speech Disabled	<input type="checkbox"/> Other:	
<input type="checkbox"/> Hearing		
<input type="checkbox"/> Late Deafness		

Reasonable accommodations (check all that apply)	
<input type="checkbox"/> Sign Language interpreter	<input type="checkbox"/> Amplified Telephone
<input type="checkbox"/> Assistive Listening System (ALS)	<input type="checkbox"/> Support Service Provider (SSP)
<input type="checkbox"/> Computer Assisted Real-Time Transliteration (CART)	<input type="checkbox"/> Large print
<input type="checkbox"/> Written notes	<input type="checkbox"/> Braille – Grade 1
<input type="checkbox"/> Captioning – TV, DVD, VHS	<input type="checkbox"/> Braille – Grade 2

AFFIRMATIVE ACTION – TO MAINTAIN DIVERSE REPRESENTATION

The shaded grey area is optional.

GENDER

- Male
 Female
 Other

RACE OR ETHNICITY

- Alaskan Native or
American Indian
 Asian or Pacific
Islander
 Black/African
American

- White/Caucasian
 Latino(a), Hispanic or Spanish
 Russian
 Other:

QUESTIONNAIRE

Please answer the following questions. You may attach additional pages.

1. How did you learn about ODHHS?
2. Reflect on a time when you challenged a belief or idea. What prompted your act? Would you make the same decision again?
3. Discuss an accomplishment or event, formal or informal, where you demonstrated a transition of empowerment within your culture, community, or family.
4. What can you bring to the ODHHS Advisory Committee that will allow a collaborative vision of partnership within the community?
5. Discuss your experience related to honoring and supporting diversity within the deaf and hard of hearing community?

6 Are there any factors which could cause a potential conflict of interest with your responsibilities as a potential ODHHS Advisory Committee member? (For example, are you a staff or board member of any organizations that contract with ODHHS?)

Members are required to attend and participate in a minimum of four (4) meetings per year and participate in subcommittee or workshop activities. Members are expected to serve as a resource, to be actively involved, to respond to mail polls and to participate in local events. If appointed as a member, I will meet this commitment.

YOUR SIGNATURE

DATE

PRINT YOUR NAME HERE

TELEPHONE NUMBER
(INCLUDE AREA CODE)