



STATE OF MISSOURI  
 DEPARTMENT OF MENTAL HEALTH  
 DIVISION OF ALCOHOL AND DRUG ABUSE - MISSOURI ADVISORY COUNCIL ON ALCOHOL AND DRUG ABUSE  
**MEMBERSHIP APPLICATION**

NAME			
MAILING ADDRESS		E-MAIL ADDRESS	
CITY		STATE	ZIP CODE
COUNTY	FAX#	HOME TELEPHONE	BUSINESS TELEPHONE
OCCUPATION		SSN	
AGE GROUP <input type="checkbox"/> UNDER 30 <input type="checkbox"/> 30-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50+		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE

BRIEF BACKGROUND STATEMENT REGARDING INVOLVEMENT WITH HEALTH SERVICES, IE., VOLUNTEER, STAFF, OTHER COUNCILS, TASK FORCE, ETC. (P LEASE ATTACH RESUME OR BIOGRAPHICAL SKETCH)

*(This area is intentionally left blank for the applicant to provide a background statement.)*

ARE YOU CURRENTLY A BOARD MEMBER, THE SPOUSE OF A BOARD MEMBER, OR AN EMPLOYEE OF ANY AGENCY HAVING A CONTRACT WITH THE MISSOURI DEPARTMENT OF MENTAL HEALTH IN EXCESS OF FIFTEEN HUNDRED DOLLARS (\$1,500)?  
 YES    NO   IF YES, COMPLETE THE FOLLOWING

NAME OF AGENCY		
STREET ADDRESS		
CITY	STATE	ZIP CODE
SIGNATURE		DATE

**THIS SECTION TO BE COMPLETED BY DIVISION OF ADA STAFF**

REGION	
THIS REQUEST IS A <input type="checkbox"/> NOMINATION <input type="checkbox"/> REPLACEMENT <input type="checkbox"/> REAPPOINTMENT - CHECK ONE: <input type="checkbox"/> 1ST <input type="checkbox"/> 2ND	
MEMBER STATUS <input type="checkbox"/> VENDOR <input type="checkbox"/> CONSUMER	
DATE TERM WILL END	APPROVED BY (DISTRICT ADMINISTRATOR)