NORTHWEST FLORIDA AIDS CONSORTIUM (NoFLAC)
MEMBERSHIP APPLICATION/AGREEMENT

It is the policy of NoFLAC to appoint and retain persons from all represented service areas, infected and affected population groups and various fields of expertise, including people who have an active interest in the care of persons living with AIDS and HIV. Members agree to (a) participate in the planning, implementation and evaluation of a comprehensive service plan for people living with AIDS; (b) to participate actively on at least one Consortium committee; (c) assist in providing information, referral, advocacy, support and education regarding HIV and AIDS and NoFLAC's mission.

PLEASE PRINT

NAME: _____

MAILING ADDRESS: _____

CITY, STATE, ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

FAX LINE: _____ EMAIL ADDRESS: _____

EMPLOYER: _____

OCCUPATION: _____

For the purpose of ensuring a membership that reflects the economic, social, racial, ethnic, sexual orientation and gender composition of the population being served, the following information is requested, *BUT NOT REQUIRED***.**

County of Residence: Escambia_____ Santa Rosa_____ Okaloosa_____ Walton_____

Other – Please Specify: _____

Date of Birth: _____ Gender (M/F): _____ Transgendered (Y/N):_____

Race: White _____ Black _____ Asian _____ American Indian _____ Hawaiian/PI _____

Other or Mixed Race – Please Specify: _____

Ethnicity: Hispanic _____ Not Hispanic or Latino _____ Other _____

OPTIONAL INFORMATION: Living with HIV/AIDS (Y/N): _____

Caregiver of family member of person living with HIV/AIDS (Y/N): _____

Sexual Orientation: Straight _____ Gay or Lesbian ____ Bisexual _____

PLEASE CONTINUE ON REVERSE

Northwest Florida AIDS Consortium

Conflict of Interest Disclosure

The Northwest Florida AIDS Consortium (NoFLAC) has members who are professionally or personally affiliated with organizations that have, or might in the future request or receive funds for HIV/AIDS prevention or patient care activities or services. Because of this potential conflict of interest, this disclosure form has been adopted and approved by the Consortium and approved by the Florida Health Department, Bureau of HIV/AIDS and must be completed by all current members in accordance with the Consortium bylaws.

By my signature below, I certify that I have read, understand and support the Consortium's bylaws and have received, read understand and support the Conflict of Interest Policy and Procedures statement. Listed below are the organizations with which I am presently affiliated.

Organization: _____

Title: _____ Period of Affiliation: _____

Organization: _____

Title: _____ Period of Affiliation: _____

Organization: _____

Title: _____ Period of Affiliation: _____

Organization: _____

Title: _____ Period of Affiliation: _____

Please attach additional pages if necessary.

The following is true to the best of my knowledge and ability:

Neither I nor my immediate family has received or intends to receive any gratuities, favors, or anything of material value by a representative of a community-based organization that might alter my ability to work objectively in the Consortium's planning process.

Consortium Member Name (please print): _____

Member signature: _____

Date: _____