MH/DS of the East Central Region Advisory Committee Application

Personal Information

First Name: Last Name:

Address:

City: State: Zip:

Phone:

Email:

Group You Represent

☐ A) Person using brain health, intellectual disability, developmental disability, or brain injury

☐ B) Provider of: *(check one)*

☐ MH services ☐ ID services ☐ BI services ☐ DD services

☐ C) Family member of a person utilizing: *(check one)*

☐ brain health services ☐ intellectual disability services

☐ developmental disability services ☐ brain injury services

1. Type of service:
2. Who is the service provider:

Please provide a brief summary of your interest in serving on the ECR Advisory Committee:

Please submit the names of two ECR Advisory Committee members who would support your application.

Name:

Name:

Please submit completed form to Diane Brecht at Diane.Brecht@unitypoint.org. Thank you.