



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: (1,060 character limit)

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.