BEHAVIORAL HEALTH ADVISORY COUNCIL OF VIRGINIA
MEMBERSHIP APPLICATION FORM
(candidates are encouraged to attend a meeting prior to membership approval by the Council)

Date of preparation: ___________________________

Name of Applicant: _____________________________________________

Last Name ____________________________ First Name ___________ MI ______

Mailing Address: _____________________________________________

Street __________________________________ Apt/Suite __________________

City __________________________________ State __________ Zip ______

Email Address: _____________________________________________

Home ____________________________ work __________________________

Telephone: ____________________________

Home ____________________________ Cell ____________________________

Work ____________________________

Primary Interest in BHAC membership – please check one

___ Person with serious mental illness
___ Person with substance use issues
___ Family member of adult with a serious mental illness and / or substance use issues
___ Parent of a child / youth with a serious emotional disturbance and/or substance use issues
___ Advocate
___ Mental Health Professional
___ Other interested person

How did you learn about membership on the BHAC?

____________________________________________________________________________

____________________________________________________________________________

Why are you interested in being a member of the Virginia BHAC?

____________________________________________________________________________

____________________________________________________________________________

What special experience, skills and abilities do you bring to the BHAC?

___ Budgeting / fiscal
___ Media
___ Legislative / public policy
___ Legal
___ Other – please specify: ____________________________________________________
Are you a state employee?  Yes ____  No ____
If yes, what agency: ____________________________________________

If you are a mental health professional, please describe the nature of your professional work and the population, public or private, that you serve:
__________________________________________________________________________
__________________________________________________________________________

Are you a member of any mental health or substance use related advocacy or support groups?  
Yes ____  No ____
If yes, what organization(s) and or support groups
__________________________________________________________________________
__________________________________________________________________________

What role(s) have you filled in these organizations?
__________________________________________________________________________
__________________________________________________________________________

Is there additional information you would like to provide that would help us evaluate your application for membership?
__________________________________________________________________________
__________________________________________________________________________

__________________________________________________________________________

We seek to have diversity in our BHAC membership. To do this we need to know with which of the following racial / ethnic groups you identify (optional).

____  White / Caucasian
____  Native Hawaiian / Pacific Islander
____  Asian
____  Native American / Alaskan Native
____  Black / African American
____  Hispanic or Latino
____  Other – please describe ________________________________________________

Mail to:  BHAC New Membership Applications
c/o Mental Health America of Virginia
2008 Bremo Road Suite 101
Richmond VA  23226

OR

Fax to:  Behavioral Health Advisory Council of Virginia
804-447-7786