Membership Application
Contact Information

Seat Assignment:

Contact Information		
First Name:	**Middle Initial:**	**Last Name:**
Home Address:		
City, State, Zip Code:		
Home Phone:	**Cell Phone:**	**May we text your cell phone?** ❑ Yes ❑ No
Home Email:	**Is this your preferred email?** ❑ Yes ❑ No, please use Business Email	
Employer *(if applicable)*:		
Business Address:		
City, State, Zip Code:	**Business Phone Number:**	
Business Email:	**Is this your preferred email?** ❑ Yes ❑ No, please use Home Email	

Demographic Information
Sex: ❑ Male ❑Female
Race/Ethnicity: ❑ White/Non-Hispanic ❑ Black/Non-Hispanic ❑ Hispanic ❑ Asian/Pacific Islander ❑ American Indian/Alaska Native ❑ Other *(please specify)*
Language(s) I speak: ❑ English ❑ Spanish ❑ Haitian Creole ❑ Other *(please specify)*
Date of Birth: **Do you give Partnership Staff permission to access your voter registration information from the Florida Department of State Voter Information Lookup website?** ❑ Yes ❑ No

Statement of Interest

Please sign and date below if the information presented on this form is complete and correct:

____________________________________ ____________________
Signature **Date**

Membership Application
Disclosure of Personal Health Information Authorization

Disclosure of Personal Health Information Authorization

I, (*print your full name*) ____, understand that if I wish to be considered for membership as a **Representative of the Affected Community** on the Miami-Dade HIV/AIDS Partnership, it is necessary to identify my HIV status. By signing this authorization, I willingly disclose my status.

THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT UNTIL REVOKED.

Please check "Yes" or "No" for each of the following statements:

❑ Yes ❑ No I am HIV positive.

❑ Yes ❑ No I am a recipient of Ryan White Part A services.

❑ Yes ❑ No I am a caregiver to an HIV positive person who is a recipient of Ryan White Part A services.

If I choose not to disclose my HIV status, I understand that I will be considered for membership in other membership categories, provided there is an open seat and I meet the qualifications for that seat.

I understand that this information will become public record and ***may*** be discussed in open, public meetings. The Florida Government in the Sunshine Law requires open discussion in a public forum. In addition, I further understand that by signing this release, I waive any exemptions of the information concerning my HIV status pursuant to Chapter 119.07 of the Florida Statutes. My status will be released to anyone who requests a copy of this document.

I further understand that I may revoke this authorization to disclose my HIV status, in writing, prior to my application being considered at the next Community Coalition Committee meeting. However, I understand that the information may have already been disclosed on the basis of this authorization.

I authorize the release and exchange of information about my HIV status among and between the Miami-Dade County Office of Grants Coordination, the Office of the Mayor of Miami-Dade County, the Miami-Dade County Office of the Inspector General, the Miami-Dade HIV/AIDS Partnership, the United States Office of Inspector General, the United States Department of Health and Human Services, and Behavioral Science Research Corporation.

______________________________________ ______________________

Signature Date

CANCELLATION OF DISCLOSURE AUTHORIZATION

I wish to cancel this Disclosure of Personal Health Information Authorization. I understand that I am entitled to a copy of this canceled Authorization.

______________________________________ ______________________

Signature Date

Membership Application
Criminal Background Check

Acknowledgement and Authorization for Criminal Background Check

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Name of Applicant

As a condition of my application for appointment to the Miami-Dade HIV/AIDS Partnership, I understand that Miami-Dade County, through the Mayor's Office, will conduct a criminal background check on me to determine my eligibility to be appointed to the Partnership. By signing this Acknowledgement and Authorization I authorize Miami-Dade County, by and through the Mayor's Office, to access such information as may be necessary to complete a criminal background check.

I release from liability all persons and entities supplying such information. I indemnify Miami-Dade County against any liability which may result from making such requests. I agree that a fax or photocopy of this Acknowledgment and Authorization form with my signature will be accepted with the same authority as the original.

____
Applicant's Social Security Number

Please fully write out your Social Security Number on the above line. The Mayor's Office will not process your application without a complete Social Security Number. The County will not publicly disclose your Social Security Number and will take all steps to prevent such disclosure.

_______________________________________ _______________________________________
Signature of Applicant **Date**

Sign and Date

I, (print your full name) ____, certify I have thoroughly read this acknowledgement. I further certify the information in this application is true and correct.

Application valid for 6 months from this date.

Signature: **Date:**

FOR OFFICIAL USE

Client #:

Date received: Date membership approved/denied: