

Alaska HIV Planning Group (HPG) Membership Application Form

Please type your responses or print clearly. The completed application can be scanned and emailed to Jessica.harvill@alaska.gov or faxed to (907) 561-4239.

Confidentiality: All information shared by applicants and participants will be kept confidential. Completed applications are reviewed only by HIV Planning Group members and are not shared with the public.

HPG Membership Application		
APPLICANT INFORMATION		
Name:		
Home Address:		
City:	State:	ZIP:
Phone Number:	Email Address:	
Membership Type: <input type="checkbox"/> Full Membership <input type="checkbox"/> Adjunct Membership		
Why are you interested in joining the HPG?:		
EMPLOYMENT INFORMATION		
Current Employer:		
Employer Address:		
City:	State:	ZIP:
Job Title or Description:		
DEMOGRAPHIC INFORMATION		
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Other		
Age: <input type="checkbox"/> < 18 years <input type="checkbox"/> 19-29 <input type="checkbox"/> 30-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50-59 <input type="checkbox"/> 60+		
Race/ Ethnicity:		
<input type="checkbox"/> African American/Black	<input type="checkbox"/> Alaska Native/Native American	<input type="checkbox"/> Asian
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Pacific Islander/Native Hawaiian	<input type="checkbox"/> White
<input type="checkbox"/> Other	<input type="checkbox"/> Decline to provide	

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EXPERIENCE

(Please check all that apply)

<input type="checkbox"/> Statistical Analysis <input type="checkbox"/> Program Evaluation <input type="checkbox"/> Epidemiology <input type="checkbox"/> Needs Assessment <input type="checkbox"/> Monitoring/Evaluation <input type="checkbox"/> Grant Review	<input type="checkbox"/> HIV/AIDS Prevention <input type="checkbox"/> STD Prevention <input type="checkbox"/> Medical/Health <input type="checkbox"/> Behavioral/Social Services <input type="checkbox"/> Drug Treatment <input type="checkbox"/> Harm Reduction/Needle Exchange <input type="checkbox"/> Prevention with Positives	<input type="checkbox"/> LGBTQ Community <input type="checkbox"/> Non-Gay Identified MSM <input type="checkbox"/> Homeless populations <input type="checkbox"/> Sex Workers <input type="checkbox"/> Injection Drug Use <input type="checkbox"/> Other: _____
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Please summarize your experience from the fields you checked above:

REFERENCES

Please provide the name and contact information for two references who either a) recruited you to join the HPG, b) are a current HPG member or, c) can attest to any of the experiences you listed above.

Name:	Relationship to you:
Phone/Email:	
Name:	Relationship to you:
Phone/Email:	

SIGNATURE

Please read each of the following carefully. Check each box to indicate that you understand, and sign below.

- [If applying for full membership only] I agree to serve on the HPG for a minimum of two years and to the best of my ability attend all HPG meetings and teleconferences
- I understand I may be asked to participate in HPG sub-committees and work groups which may require work outside the quarterly HPG meetings
- I give permission to share any of the information I have provided in this application with the HPG membership committee for the purpose of membership review and selection

Signature:	Date:
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