MHPC

The Mississippi HIV Planning Council

MHPC Membership Application Form

All information provided on this application will be kept **CONFIDENTIAL.**

MHPC is seeking results-oriented stakeholders with lived experience, expertise, and a commitment to the values of positive collaboration and integrity to serve on the MHPC. Individuals, stakeholders or organizations are invited to submit an application for membership. Please note that a submission of an application does not guarantee membership access to MHPC.

Prior to being seated as a MHPC member, it is a requirement to complete new member orientation. If seated as a MHPC member, your term will be for two consecutive years. All MHPC members and/or their assigned proxy (substitute) are required to attend all MHPC meetings, be active on at least one standing committee and active on at least one work group committee.

There is no financial compensation for service on the MPHC.

However, reimbursement can be requested for any approved travel associated with MHPC activity.

Please complete the form below and return to the Mississippi Public Health Institute at MHPC@mshpi.org.
Deadline for applications is Wednesday, December 20, 2023 at 5:00 pm CST.

First Name: _____ Last Name: _____

Physical Address: _____
Street and Post Office Box/ Apartment Number

City, State and Zip Code _____ County _____

Mailing Address: _____
Street and Post Office Box/ Apartment Number

City, State and Zip Code _____ County _____

Do you have your own transportation? ☐ Yes ☐ No

Work Phone (____) _____ Personal Phone (____) _____

Work Email _____ Personal Email _____

Employer _____ Title _____

Education _____

Gender Identity:

- ☐ Female
- ☐ Male
- ☐ Non-binary/Non-conforming
- ☐ Transgender female
- ☐ Transgender male
- ☐ Other
- ☐ Prefer not to answer

Age:

- ☐ 16-19
- ☐ 20-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60+

Race/Ethnicity:

- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Black/ African American
- ☐ White/Caucasian
- ☐ Hispanic
- ☐ Native American/Alaskan Native
- ☐ Other (Please specify) _____

Indicate which category you would be able to represent as a member of the MHPC. (Check all that apply)

☐ **Individual**

- ☐ Person with HIV or AIDS ☐ HIV/AIDS Advocate ☐ Family/Friend of a PWH
- ☐ Member of Community or Group Disproportionately Impacted by HIV/AIDS
- ☐ Faith-Based Leader/Clergy ☐ Business Professional ☐ Political Official
- ☐ Other: _____

☐ **Organization**

- ☐ HIV Service Providers (name of organization) _____
  - ☐ Prevention ☐ Care ☐ Other _____
- ☐ Other (Non-HIV) Service Provider (name of organization) _____

  Type of service provided _____

☐ **Stakeholder**

Individual or organizational – A person or representative of an organization who has personal or professional experience or expertise that is useful for HIV Prevention and Care.

Name of Organization _____

Why do you want to be a member of MHPC?

What qualifications, special skills, expertise or experience will you bring to MHPC?

List the populations or groups you will be able to impact as an MHPC member:

Which NHAS Goal related work group you would like to serve on?

☐ Goal #1 – Reducing New HIV Infections

☐ Goal #2 – Increasing Access to Care and Improving Health Outcomes for PLWH

☐ Goal #3 – Reducing HIV- related Disparities and Health Inequities

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Please provide the name, phone number, and email address of three professional and or personal references

1. _____

2. _____

3. _____

I certify that all information provided in this application is true and complete. I understand that any false information or omission may disqualify me from further consideration for MHPC membership and may result in my dismissal, if discovered at a later date. I also acknowledge that I am capable of completing all duties related to being a member of MHPC and by my signature I consent to this statement.

Signature: _____ Date: _____

Membership Committee Use Only

Date Reviewed: *Committee Action:* ☐ *Approved* ☐ *Not Approved* ☐ *Need additional information*