2020 APPLICATION FOR NOMINATION TO SERVE ON THE BOARD OF TRUSTEES
OF THE PUBLIC HEALTH TRUST OF MIAMI-DADE COUNTY

Mission
To provide a single high standard of health care, education and research

To improve patient and customer satisfaction, enhance professional fulfillment and provide public service

Chapter 25A of the Miami-Dade County Code states that the governing body of the Trust shall consist of 7 voting members, none of whom shall be employees of the Trust. Board members are appointed to the Trust during the annual appointment process or through a special convening of the Nominating Council. The membership of the Board of Trustees should be representative of the community at large and should reflect the racial, gender, ethnic and disabled make-up of the community. Candidates will be screened for any potential conflict of interest with the responsibilities of a Board member.

Completed applications and resumes can be mailed or hand delivered to the address below by **February 21, 2020 at 4:00 pm**. Emails or facsimiles of the application and resume will be accepted and can be sent to clerkbcc@miamidade.gov or faxed to 305-375-2484. It is the responsibility of the applicant to ensure electronic receipt of the application and resume by calling the Clerk of the Board at 305-375-1652.

Clerk of the Board of County Commissioners
ATTENTION: Linda Cave
111 NW 1st Street, Suite 17-202
Miami, Florida 33128
(305)375-1652

**ATTENTION APPLICANTS:** BACKGROUND CHECKS WILL BE PERFORMED ON ALL APPLICANTS SELECTED FOR AN INTERVIEW. IF SELECTED, TRUSTEES WILL BE REQUIRED TO SUBMIT FINANCIAL DISCLOSURE FORMS.
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Biographical Profile

Name: ________________________________________________________________

Last       First       Middle

Employer:____________________________________________________________

Title/Occupation:_______________________________________________________

Business Type:________________________________________________________

Business Address:_______________________________________________________

Business Telephone: ________________________ Fax: _________________________

Email Address:________________________________________________________

Home Address:________________________________________________________

Home Telephone:_______________________________________________________

Date of Birth: ___________ Length of Residence in Miami-Dade County: __________

PLEASE CHECK APPROPRIATE INFORMATION LISTED BELOW (Optional)

□ Male

□ Female

□ White Non-Hispanic

□ Black Non-Hispanic

□ Hispanic

□ Asian or Pacific Islander

□ American Indian or Alaskan Native

□ Haitian American

EDUCATION:

School/City/Major/Degree:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Previous Employment and Professional Background:

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<th>Business Name</th>
<th>Position</th>
<th>Years</th>
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EXPERIENCE AND/OR QUALIFICATIONS:

Describe how your past experience and/or qualifications would benefit the Public Health Trust:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

ORGANIZATIONS AND ACTIVITIES:

List community, civic, professional and other organizations of which you are a member:

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<th>Organization</th>
<th>Position Held</th>
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List any Public Office held (Elected or Appointed):

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Affiliations with hospitals, nursing homes or other health related institutions:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Activities reflecting community interest:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

List all potential conflicts of interest, including potential conflicts arising from your relationships or the relationships of any of your family members in the healthcare industry:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

References - Persons acquainted with candidate’s activities/experience:

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<th>Name</th>
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Please describe the goals and objectives you will seek to accomplish if you are selected as a Trustee:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
I, (candidate’s name) ____________________________________________,
Citizen of the United States, a duly qualified elector of Miami-Dade County, and not
affiliated with the Public Health Trust of Miami-Dade County or its subordinate agencies
or institutions, would, if appointed, be willing and able to discharge the responsibilities
and functions of Trustee. I declare that, if selected while currently serving on another
official County board, I will resign from my other County responsibilities.

__________________________  ________________________________
Date                                    Candidate’s Signature

Nominated by (if not self):

__________________________  ________________________________
Name                                    Telephone

__________________________  ________________________________
City                           State                      Zip Code