

AREA AGENCY ON AGING, PSA 2  
ADVISORY COUNCIL  
APPLICATION FORM

**Representative for Logan County**

Thank you for your interest in our program. Please print or type the following information.  
Feel free to attach continuation pages and/or letters of support.

Name:	<input type="checkbox"/> I am a resident of the county. <input type="checkbox"/> I am not a resident, but I work in the county.
Address:	Home phone: Work phone: E-mail:
Occupation:	Employer:
Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate:
How long have you been a resident of this county?	
Race: Caucasian <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/>	
Do you have a disability? yes <input type="checkbox"/> no <input type="checkbox"/>	
Are you a consumer of services funded by the Area Agency on Aging? yes <input type="checkbox"/> no <input type="checkbox"/> uncertain <input type="checkbox"/>	
Are you employed by, or hold financial interest in, an agency receiving funds from the Area Agency on Aging? yes <input type="checkbox"/> no <input type="checkbox"/> uncertain <input type="checkbox"/>	
Experience in working with older adults, elderly services programs, senior citizen centers, etc. (especially emphasize any leadership experience):	
Relevant organizations to which you belong:	

Special Interests:

I have reviewed the enclosed position description for Area Agency on Aging Advisory Council members. I understand that appointment to the position involves participation in the responsibilities of being a representative of my county to this council.

I agree to notify the Area Agency if a conflict of interest arises. I understand that I will be asked to resign should such a conflict occur, or if it is determined that I am not fulfilling the duties of the office.

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application as may be necessary in arriving at a decision.

Signature of applicant and date:

**DEADLINE FOR SUBMISSION IS MAY 4, 2018.**

MAIL TO: AREA AGENCY ON AGING, PSA 2  
ATTN: KARIN NEVIUS  
40 WEST SECOND ST., SUITE 400  
DAYTON, OH 45402

**For Office Use Only:**

Was applicant appointed?      yes       no

Type of appointment:      new       replacement

Effective date of appointment: