LHRC APPLICATION FORM

NAME OF LHRC: Select LHRC name below:

Select from dropdown list

Today's Date:

First and Last Name: Email address:

Mailing Address: Telephone #:

City, State*, Zip:

*If you live in a state bordering Virginia, please briefly explain your affiliation with the Virginia Behavioral Health system (text fields are limited, please use both lines if necessary):

Current (or most recent) Employer:

Employer's Address:

Dates of Employment: From to

Occupation/ Profession (if retired, list previous occupation):

Educational Background:

Please check categories in which you are eligible and willing to serve:

Family Member	**Individual**	**Healthcare Provider**	**Other Professional**
☐	☐	☐	☐

Family Member means an immediate family member of an individual receiving services or the principal caregiver of that individual. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the individual receiving services.

Individual means a person who is currently receiving mental health, developmental or substance use treatment or services, or who has received services within the last 5 years.

Healthcare Provider means a person who is currently employed by an entity or organization offering services licensed, funded, or operated by the Department of Behavioral Health and Developmental Services, including all persons who are licensed, certified, or registered by any of the health regulatory boards within the Department of Health Professions, except the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

Other Professional shall include lawyers, teachers and other persons with interest or knowledge or training in the treatment of mental illness, developmental/intellectual disabilities and/or substance use disorders.

LHRC APPLICATION FORM
(CONTINUED)

Have you ever been employed by, or a member of, the board of directors for a Community Services Board or Behavioral Health Authority? Yes ○ No ◉

If Yes, name of program (or programs): _____

Capacity in which you served: _____

Dates of service: From to

Have you ever been a volunteer of a program operated by the Department of Behavioral Health and Developmental Disabilities? Yes ○ No ◉

Dates of service: From to

Name of Program

Please describe your education, training, and/or experience in the areas of Mental Health, Developmental/Intellectual Disabilities and Substance Use Disorder Services:

What is your interest in serving on a Local Human Rights Committee?

As a member of the Local Human Rights Committee and based on your understanding of this Committee's meeting schedule, how will you ensure physical attendance at all required meetings and (virtual) participation in all required training sessions?

Please provide any additional information you think is relevant to your application:

_____ _____

Applicant's Signature: Signature of OHR Reviewer:

Thank you for your interest in serving on a Local Human Rights Committee. Please return completed applications to the Regional Manager in the area you wish to serve. You may access our most current regional map on the OHR web page or by clicking here.