



Healthy Start Coalition of Sarasota County
Appointment of Authorized Voting Representative¹

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____ E-MAIL: _____

NEW MEMBERS: Please complete.²

Gender: Male Female

Race: White Black Am Indian Asian Other

Ethnic Group:

Hispanic Non-Hispanic Other _____

I represent:

- Migrant and Community Health Center; County Health Dept; Birthing Facility;
- Maternal or Infant Care Provider; Medical Society; Health Advocacy Interest Group;
- Local Health Planning organization; County or Municipal Government; Education;
- Social Service Organization; Consumer of family planning, primary care or prenatal care services; Other: _____

Authorization:

_____ (Member's Name) has been named the authorized voting representative of _____ (Agency) to the Healthy Start Coalition of Sarasota County.

Date: _____ **Signature of Executive Director/CEO:** _____

I agree to comply with the provisions of all statutes relative to Healthy Start Coalition membership and participation. I agree to the responsibilities and obligations therein.

DATE: _____ (mo/day/yr) **SIGNATURE:** _____

Sworn to me and subscribed before me this _____ day of _____, 200_____

Notary Public

My Commission Expires: _____

¹ In keeping with 10D-113.005 of 383.216(10) F S. which states in part, "there shall be no more than one member who represents any one agency or organization. There shall be no more than one voting representative of the same agency or organization from a county on a coalition."

² In keeping with 10D-113.005 of 383.216(10) F S. which states in part, "each coalition shall represent health care providers, the recipient community, and the community at large: shall represent the racial ethnic and gender composition of the community."