

PARENT PANEL ADVISORY COUNCIL (PPAC)

MEMBER APPLICATION

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ COUNTY: _____

STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ FAX: _____

E-MAIL ADDRESS: _____

ARE YOU EMPLOYED BY THE STATE, OR A MENTAL HEALTH, DRUG AND ALCOHOL TREATMENT OR PREVENTION ORGANIZATION?

(circle) YES NO

IF YES, PLEASE LIST EMPLOYER:

(Please note: No person employed by the state mental health, or drug and alcohol treatment or prevention organizations can serve on the Advisory Council.)

MEMBER APPLICATION QUESTIONNAIRE

1. Are you the parent or guardian of a child who has/had a substance use disorder? YES NO

2. Is your son/daughter an adolescent or adult?

3. Why do you want to be a part of PPAC?

4. What was your main concern when trying to access treatment for your son or daughter? What went well in accessing information / help?

5. Are you willing to travel to Harrisburg once every 4 months to attend meetings? YES NO

6. Do you currently serve on any other committees that addresses substance Use disorders? If yes, please indicate:

8. Any additional comments you feel would be helpful to the selection process:
(continue on reverse side if necessary)