



Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

August 20, 2010

Dear Concerned Citizen:

The Florida Department of Health's Division of Family Health Services, Bureau of Chronic Disease Prevention and Health Promotion is committed to recruiting members to serve on advisory councils, committees, and other ad hoc groups to assist the bureau in addressing chronic disease policies, programs, issues, and concerns. We are currently seeking members for our Florida Preventive Health Advisory Committee.

The purpose of this Committee is to make recommendations to the Department of Health regarding funding allocations, assessments of public health and related activities, identification of relevant programs or entities that should be involved in carrying out recommended activities, and the collection and reporting of data. In addition, the Committee will mobilize individuals, communities, healthcare providers, healthcare payors, and policymakers to use prevention strategies in improving the health and well-being of Floridians across the lifespan. More information can be found in the enclosed document.

If you are interested in serving on this committee, please complete the enclosed application and send it by email to Ayasha Richardson at Ayasha_Richardson@doh.state.fl.us.

Sincerely,

A handwritten signature in cursive script that reads "Ana Maria Viamonte Ros".

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

AVR/ar
Enclosures

cc: Ms. Annette Phelps
Ms. Betsy Wood



As a requirement of federal regulations for the Preventive Health and Health Services Block Grant (PHHSBG), the Florida Department of Health (Department) must convene an advisory committee at least twice annually* to make recommendations regarding funding allocations; assessments of public health and related activities; and relevant programs or entities that should be involved in carrying out recommended activities. The PHHSBG currently funds the Healthy Communities, Healthy People Program, which addresses chronic disease, the Dental Health Fluoridation Program, and the Sexual Violence Prevention Program. In addition, the committee is expected to mobilize individuals, communities, healthcare providers, healthcare payers, and policymakers to use prevention strategies in optimizing the health and well-being of Floridians across the lifespan. In 2010, the Committee will also assist the Department in conducting a needs assessment to determine chronic disease priorities in Florida. This activity addresses the first goal of the PHHSBG, which is “To decrease premature death and disabilities due to chronic diseases and injuries by focusing on the leading preventable risk factors.”

Individuals will be appointed to the Committee by the State Surgeon General and will serve staggered four year terms. Members are expected to attend meetings and conference calls and maintain an ongoing engagement with organizations and individuals from the group they represent.

Individuals interested in being considered for membership should complete and mail, fax, or email the attached form to:

Florida Department of Health
Bureau of Chronic Disease Prevention and Health Promotion
4052 Bald Cypress Way, Bin A-18
Tallahassee, Florida 32399-1744
Phone: (850) 245-4330
Fax: (850) 414-6625
Email: ayasha_richardson@doh.state.fl.us

(Please print and sign. Submit by mail, fax, or email (scan signed copies). Electronic signatures are not accepted).

For additional information, please contact Ayasha Richardson (850) 245-4330 ext. 2830

**During 2010, meetings may be called on a monthly basis to assist with the needs assessment.*

Florida Preventive Health Advisory Committee Membership Application Form

Name:			
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First

Middle Initial

Last

***Gender:** Female Male

***Race/Ethnicity:** (Check all that apply)

- American Indian/Alaskan Native
- Asian/Pacific Islander
- Black/African American
- Haitian (Any Race)
- Hispanic (Any Race)
- White/Caucasian
- Other/Unknown _____

Certificates/Degrees held (if any):
Position Title (if any):

Please provide information on the agency that you will be representing within the Committee:

Agency Address:
City/State: County:

Contact Information (please enter area code):

Agency Phone:	Fax:
Cell Phone:	Other:

Email Address:

* This information will be used to provide demographic statistics and is not requested for the purpose of discriminating on any basis.

Category of Interest/Expertise (check all that apply to you):

- | | | |
|---|--|--|
| <input type="checkbox"/> Advocacy group | <input type="checkbox"/> Dental Professional Association | <input type="checkbox"/> Research organization |
| <input type="checkbox"/> Business, corporation, or industry | <input type="checkbox"/> Department of Health | <input type="checkbox"/> Schools of public-health |
| <input type="checkbox"/> College and/or university | <input type="checkbox"/> Faith-based organization | <input type="checkbox"/> Sexual Violence Prevention/Intervention |
| <input type="checkbox"/> Community-based organization/coalition | <input type="checkbox"/> Hospital or health system | <input type="checkbox"/> State or local government |
| <input type="checkbox"/> Community health center | <input type="checkbox"/> Managed care organization | <input type="checkbox"/> Substance abuse or Mental health organization |
| <input type="checkbox"/> Community resident | <input type="checkbox"/> Medical society or organization | <input type="checkbox"/> Tobacco control organization |
| <input type="checkbox"/> Community planning | <input type="checkbox"/> Minority-related organization | <input type="checkbox"/> Youth serving organization |
| <input type="checkbox"/> County and/or local health department | <input type="checkbox"/> Public and/or private school (K-12) | <input type="checkbox"/> Other (specify): _____ |

What particular skills or expertise would you bring to the committee/group? (Check all that Apply)

- | | |
|--|--|
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Policy Development |
| <input type="checkbox"/> Community Assessment | <input type="checkbox"/> Program Evaluation/Monitoring |
| <input type="checkbox"/> Epidemiology | <input type="checkbox"/> Strategic Planning |
| <input type="checkbox"/> Health Education | <input type="checkbox"/> Surveillance |
| <input type="checkbox"/> Partnership/Capacity Building | <input type="checkbox"/> Other (specify): _____ |

Please answer the following questions as completely as possible (use the back a separate page if necessary):

Have you participated in community planning (i.e., needs assessments), health planning, or other similar group planning processes? If so, please describe.

Please describe, if any, your public health and/or chronic disease experience?

Why are you interested in becoming a member of the Florida Preventive Health Advisory Committee?

Are there any conflicts of interest that may prohibit you from serving as a member of Florida Preventive Health Advisory Committee? Yes No

If yes, please explain:

Is there any additional information you would like us to consider when reviewing your application?

By signing this Application Form, I certify that all information contained herein is true and accurate to the best of my understanding. I also certify that I have read and understand the membership expectations, guidelines, and if accepted for membership, will fulfill all membership expectations as put forth by this council.

Signature: _____
Original Signature Required

Date Submitted: _____

If possible, please attach a current bio to this Membership Form for our files. Additional materials may also be attached and submitted for consideration.