



STAKEHOLDER COUNCIL APPLICATION FORM

Thank you for your interest in becoming a Stakeholder Council member to shape the future of Oregon Health Network. Your expertise, ideas, and input are crucial to carrying out the mission and values of OHN. Please fill out the application completely and email to volunteer@oregonhealthnet.org.

1 CONTACT INFORMATION

Name _____ Title _____
Organization _____ Email _____
Address (City, State, Zip) _____ Phone _____

2 HOW WOULD YOU DESCRIBE YOURSELF? Please check one box. If more than one category applies, please check where you would most likely participate or lead decision making regarding OHN's assessment of industry challenges, opportunities, and future service offerings.

- | | |
|---|---|
| Representative of health system that includes hospitals and clinics | Consumer advocate or advocacy organization |
| Representative of a hospital (group) | Representative of a health care education organization |
| Individual health care provider | Representative of a company that provides HIE/HIT technology solutions |
| Representative of provider organization, clinic or association | Representative of a health plan (insurance provider) |
| Representative of a state or local government agency | Representative of a purchaser of health care (not a health care provider) |
| Private citizen (patient, consumer of health care services) | Representative of a tribe |
| | Other (please specify) _____ |

2a You answered "Individual Health Care Provider." Which of the following most closely describes your occupation?

- | | |
|--|---|
| Mental and/or behavioral health provider | Oral health provider |
| Physician | Technician |
| Nurse Practitioner, Nurse, LPN, LNA, or other licensed nurse | Complementary and Alternative Medicine Provider |
| Physician's Assistant | Other (please describe) _____ |
| Mid-wife | |

2c You answered, "Representative of a provider organization, clinic, or association." Please elaborate on your organization type.

- | | |
|-------------------------------------|--------------------------------|
| Physician organization or clinic | Provider association |
| Other type of provider organization | Other (please describe): _____ |

2d You answered, “Representative of a purchaser of health care (not a health care provider).” What best describes your organization?

Public program purchaser (state or local government)

Not-for-profit business

For-profit business

Union

Coalition of public & private purchasers

Other (please specify): _____

2d You answered, “Health Care Education Organization.” Please describe your organization and programs offered.

2-year degree

4-year degree

Explain degree programs offered

3 IF MEETINGS, WEBINARS, OR CONFERENCE CALLS ARE HELD, WHICH TIMES WOULD BE MOST CONVENIENT FOR YOU? (Select all that apply)

Varies, hard to say

Weekday mornings

Weekday afternoons

Anytime

Weekday evenings

Would not participate in a meeting, webinar, or conference call

4 IF IN-PERSON MEETINGS ARE HELD, WHICH LOCATION(S) WOULD BE MOST CONVENIENT FOR YOU? (Select all that apply)

Portland

Salem

Eugene

Hillsboro

Bend

Medford

Lincoln City

Pendleton

Would not attend in-person meeting

5 PLEASE CHECK ALL FIELDS OF EXPERTISE THAT APPLY TO YOU.

Healthcare: Direct Clinical Patient Care

Healthcare: Tele-health (Remote or Consultative Care)

Healthcare: Business Management

Healthcare: Electronic Patient Records

Education & Distance Education

IT Applications

IT Networking

IT Management

Information Security

Governmental Policy, Regulation, Partnership, Development

Other (please describe)

Thank you for your interest in Oregon Health Network. Please email completed applications to: volunteer@oregonhealthnet.org. Questions? Contact Kim Lamb, OHN Executive Director, at 503-344-3742.