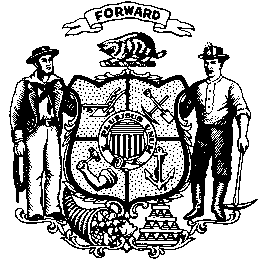
1 W. Wilson, Room 851

PO Box 7851

Madison, WI 53707-7851

Voice: 608-261-9316

Fax: 608-267-7793

Wisconsin

Council on Mental Health

**Please return completed form via email at:** [**WCMH@wisconsin.gov**](mailto:WCMH@wisconsin.gov)

**Council Applicant Contact Information**

* Name:
* Mailing Address:
* Home Address (List “N/A” if same as Mailing Address):
* Preferred Telephone Number (e.g., 555-555-5555):
  + Is your preferred phone number for a mobile phone or a home phone (landline)?
  + Optional: Secondary phone number (mobile or home phone):
* Email Address:
* Job title:
  + Employer:
  + Preferred Mailing Address (home or work):
  + Work address:
  + Work phone (e.g., 555-555-5555):
* Date of birth (e.g. 11/05/1951):
* Gender:
* Race/Ethnicity (you may list multiple answers)
* Veteran Status:
* Your Social Media Information (optional)
  + LinkedIn:
  + Facebook:
  + Twitter:
  + YouTube:
  + Other:
* Please list any accommodations you may need in the application process or if selected to serve on the council:
* Other Contact Information/Notes:

**Wisconsin Council on Mental Health**

**Applicant Questionnaire**

1. Please check all that apply below:

I am a provider[[1]](#footnote-1) of mental health services. Please check if you are:

Provider in Private Practice (specify your role and affiliation/agency)

Provider in the public mental health system (specify your role and affiliation/agency)

Other Mental Health Provider (specify)

I am a state employee (specify your role and agency/affiliation below)

I am a young person (up to age 21 years) with a serious emotional disturbance or serious mental illness. Please list your age below:

I am an adult (21-55) person with a serious mental illness (consumer)

I am an elder (55+) person with a serious mental illness (consumer)

I am a family member of an adult with a serious mental illness (specify your relationship below):

I am a parent of one or more minor children (age 18 years or younger) with a

serious emotional disturbance[[2]](#footnote-2). Please list their age(s) below:

I represent a public or private mental health advocacy organization or agency concerned with the need, planning, operation, funding, provision or use of mental health services, or support services. Please list the agency or agencies:

I represent a public or private consumer-run organization or agency (not-for

profit with at least 50+ % consumers on the oversight Board)

I am an elected government official. Please specific your role and government agency:

2. Please list the mental health, advocacy, consumer-run and other groups or organizations (voluntary, program, business, political, school, local, etc.) where you are currently an active participant, and describe your role in the group or organization.

3. Please describe your volunteer or work experience, if any, with state or local mental health issues, policies, legislation, or concerns. Please describe the topics/concerns you were interested in, who you worked with, and what resulted.

4. Please describe your specific experience, background, knowledge, skills, abilities, personal qualities, training, professional license/certification or any other factors that you feel makes you a well-qualified candidate for the State Mental Health Council position.

5. Is there a specific mental health constituency/group you would prefer to represent on the Wisconsin Council on Mental Health? and what is your reason for identifying this group (e.g. mentally ill children, elders, adults, mentally ill persons involved in the criminal justice system, public or private mental health systems, providers)?

6. Are you willing to consider taking a leadership role on the Council regarding issues you are interested in, after a period of mentoring and familiarization with Council activities and processes?

Yes No

7. Please attach the names of two or three people who can be contacted as your references. At least two should be individuals who you interacted with as part of your answers to Questions 1, 2, 3 or 4. Others may be individuals who know you well. Please give each person’s name, title, address (work or home) and daytime phone number so that we may contact them.

8. Reference Letter (optional) - If you have a reference letter, you may attach it with this application.

9. Cover letter - Please attach a copy of your cover letter to this application.

10. Resume/CV - Please attach a copy of your resume/CV to this application.

11. Did anyone refer you to apply?

12. Who referred you to apply? (if applicable)

13. Under Wisconsin Statutes 19.36(7)(b), as an applicant for this position, you have the limited right to request that your identity be kept in confidence. If you wish to preserve this right, you must select "yes" below.  
This right prevents your identity from being released in response to a public records request unless; you are appointed to the position or you are a finalist for the position as defined by Wisconsin Statute 19.36(7)(a).  
 Yes, I request confidentiality  No, I do not request confidentiality

14. By submitting this application you are affirming that all the statements you have made in this document are true and that you understand that an extensive background check may be conducted if you are considered for appointment.  
 I agree  I disagree

1. A physician treating any patient’s mental health condition, a practicing psychologist, any other practicing, licensed provider of mental health services or any other person whose employer provides treatment for mental health conditions. [↑](#footnote-ref-1)
2. Persons: (1) from birth up to age 18 and (2) who currently have, or at any time during the last year had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R. *Federal Register*, Vol. 58, No. 96, May 20, 1993, pp. 29422 - 29425. [↑](#footnote-ref-2)