Maryland Nursing Workforce Commission
BIOGRAPHICAL INFORMATION FORM

Please complete the information below for consideration for appointment to the Maryland Nursing Workforce Commission.

Name: ______________________________ License Number: _________________

Social Security Number: _________________ Date of Birth: _________________

Home Address: ____

City: ____________________ State: ___________ Zip Code: ______________

County of Residence: ___________________________

Place of Employment: ___________________________________

Occupation: ____

Business Address: ____

City: ___________________ State: ____________ Zip Code: _______________

Business Phone: ___________________ Home Phone: ___________________

Fax: _____________________ Cell Phone: _________________________

E-Mail: ____

Preferred Mailing Address (check one): ______Business ________Home

Race: ______ Gender: _____(Race & gender data is solely for assuring diversity in representation.)

Committee Selection:

____ Education
____ Marketing
____ Membership
____ Nursing Technology
____ Recruitment
____ Workplace/Retention

Sponsoring Organization: ____

Are you an officer or director of a professional association? _____Yes ___ No

If "yes", enter name of association(s): ____

Are you engaged in lobbying activity for any organization or association? ___ Yes ____No

If "yes", enter name of organization(s) or association(s): _____________________________

(Continued)

Supplemental Questions

1. What is your interest in serving on the Commission?

2. What will you contribute to the Commission?

3. How would you carry out the liaison role between the Commission and your sponsoring organization?

4. Describe how you will achieve the attendance obligation of the Commission.

Alternate Contact Information. If unavailable, please submit at the first Commission meeting.

Name: ________________________________

Home Address: ____

City: ____________________ State: ___________ Zip Code: ______________

Business Phone: ___________________ Home Phone: ___________________

E-Mail: ____

Preferred Method of Contact (check one): ____ Business ____ Home ____ Email

Please attach a resume, which includes information on your academic background, work experience, and professional, political and civic organization affiliations.

Return the requested information to:

Patricia Kennedy, Special Assistant Maryland Board of Nursing
4140 Patterson Avenue, Baltimore, Maryland 21215-2254
FAX: 410-358-3530 **Phone**: 410-585-1922