

# ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY (ACTPCMD)

## Applicant Information Form

### CONTACT INFORMATION

Name:		Date:
Position:		
Organization:		
Business Address:		
City:	State:	ZIP Code:
Phone:	Fax:	Email:
Home Address:		
City:	State:	ZIP Code:
Phone (opt):	Fax (opt):	Email (opt):

### APPLICANT SPECIFIC INFORMATION

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a U.S. Citizen?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth:	Place of Birth:
Race/Ethnicity	
<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White/Non-Hispanic <input type="checkbox"/> Other (specify): _____	
Geographic Area of Representation: <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural	

### VACANCY INFORMATION

The ACTPCMD is currently seeking nominees that can represent the following categories:

- Family Medicine
- General Internal Medicine
- General Pediatrics
- Physician Assistants
- General Dentistry
- Pediatric Dentistry
- Dental Hygiene
- Advanced Practice Nursing

Please check the category or categories that best represents you and your qualifications.

### PAST COMMITTEE INVOLVEMENT

Are you now serving on any advisory committee for the Health Resources and Services Administration (HRSA)?  
 Yes  No  
If "yes", which committee(s): \_\_\_\_\_

Have you served on any advisory committee for HRSA within the past 12 years?  
 Yes  No  
If "yes", which committee(s) and when: \_\_\_\_\_

### NOTES

Please include your CV with this Applicant Information Form  
For additional information on the ACTPCMD contact Shane Rogers at 301-443-5260 or [srogers@hrsa.gov](mailto:srogers@hrsa.gov)