North Dakota ASSISTIVE Assistive Technology

CONSUMER ADVISORY COUNCIL
MEMBERSHIP APPLICATION

1. Name _____

   Mailing Address _____

   _____

   E-mail Address _____

   Agency/Region _____

   Home Phone _____

   Work Phone _____

   FAX _____

2. Representation (Check all that apply):

   ☐ An individual with a disability
   ☐ A parent, spouse, child, or guardian of an individual with a disability
   ☐ Agency Representative

3. Personal experience with assistive technology:
   _____

   _____

   _____

4. Areas of Expertise (professional or personal):

   _____

   _____

   _____

   _____

5. Groups you have links to: _____

   _____

   _____

6. Areas of interest: _____

   _____

   _____

7. Responsibilities: Please indicate your willingness to take on these responsibilities:
   a. Attend meetings that are scheduled quarterly: Yes ☐ No ☐

   b. Participate on various subcommittees to prepare reports or plans:
      Yes ☐ No ☐

   c. Gather and report information on the need to develop and expand Assistive Technology services regionally and statewide:
      Yes ☐ No ☐

8. Please list 3 references other than family members:

   1. Name _____

      Address _____

      Phone _____
   2. Name _____

      Address _____

      Phone _____
   3. Name _____

      Address _____

      Phone _____

Assistive
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