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Wyoming Department of Health

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Thomas O. Forslund, Director **Governor Matthew H. Mead**

Wyoming Developmental Disabilities Advisory Council
Membership Application

Thank you for your interest in becoming part of the Developmental Disabilities Advisory Council!

The Developmental Disabilities Advisory Council (Council) exists by authority of W.S. 9-2-107(a) for the purpose of advising the Developmental Disabilities Division (Division) staff on formulating and amending rules, policies, and procedure relating to Division programs and activities. The purpose of the Council is to assist and advise the Division in implementing a statewide service delivery system for persons who are identified as having developmental disabilities and their families.

The Developmental Disabilities Advisory Council is made up of ten members, for a term of three years. The Council membership is made up of the following representation:

- *At least two members of the Council must be comprised of legally authorized representatives of a person with developmental disabilities or acquired brain injury or a self advocate.*
- *At least two members must be Wyoming public or private providers of early intervention services, developmental disability services or acquired brain injury services.*
- *At least one member must be from the State educational agency responsible for preschool services to children with disabilities.*
- *One member representing each of the three branches of the Administration on Developmental Disabilities, i.e. The Governor's Council on Developmental Disabilities, Protection and Advocacy, Inc. and Wyoming Institute on Disabilities (WIND).*

The Council meets 2-4 times per year, in locations around the state or by conference call. Council members are appointed by the Director of the Wyoming Department of Health and serve without compensation. You may find a copy of the Council's current by-laws on the Division's website at: http://www.health.wyo.gov/ddd/ddadvisorycouncilhome.html

Please complete the following application. If you have any questions regarding the Council or this application, please call Dani Sullivan at (307) 777-7359 or (800) 510-0280. Please Note: Applications to the Council are accepted at any time and will be kept on file for a two (2) year period.

Please submit applications to:

Mail	Fax	Email
DD Advisory Council Attn: Dani Sullivan 6101 Yellowstone Road Suite 186C Cheyenne, WY 82002	Attn: Dani Sullivan (307) 777-6047	ddadvisorycouncil@health.wyo.gov

Sincerely,

Chris Newman, Administrator
Developmental Disabilities Division

Joe Simpson, Deputy Administrator
Developmental Disabilities Division

Developmental Disabilities Advisory Council Membership Application
Please type or print

Full Name:_____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Home/Cell Phone: _____ Work Phone: _____

What is your interest in being on the DD Advisory Council?

_____
_____

What position are your applying to fill?
☐ Legal representative of a person with DD/ABI ☐ Self Advocate ☐ DD/ABI Service Provider
☐ Early Intervention Service Provider ☐ WY Dept. of Education ☐ WY Governor's Council on DD
☐ Protection & Advocacy ☐ WY Institute on Disabilities (WIND) ☐ Other: _____

Occupation, profession, or position (please include employer's name):

_____

Education (please list degrees, schools and dates):

_____
_____

Please provide a brief summary of your work experience:

_____
_____

Please list any Boards, Commissions or other organizations to which you currently belong, as well as offices held:

_____
_____

Please list any circumstances that may restrict your availability to serve, if any:
☐ Not Applicable

_____

Please feel free to provide us with any additional information you believe would assist us in our appointment process. Use additional sheets if necessary. Letters of recommendation are welcome but not a requirement.
☐ Additional pages attached

_____
_____

I certify that all information contained on this application is true and complete to the best of my knowledge. I understand any misrepresentations or falsifications may result in removal of appointment.

Signature_____ Date _____

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