



Date: \_\_\_\_\_

**MEMBERSHIP REGISTRATION FORM- Please Print**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Agency/Business Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Alternate phone:(\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Primary language: \_\_\_\_\_ Secondary language: \_\_\_\_\_

By submitting this form, you are asking the CMHP to **join or confirm Membership** in the CT Multicultural Health Partnership. After completing this form, you will be contacted by someone at the CMHP and also added to our mailing lists. Contact us with questions.

- **"I am already a member** of the Partnership and I would like to get more involved a Committee":  **Yes**  **No**

- I would like to **join the following Committee** (Please check one):

- |                                                   |                                                           |
|---------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Awareness & Outreach     | <input type="checkbox"/> Communication and Media          |
| <input type="checkbox"/> Consumer Initiatives     | <input type="checkbox"/> Data Surveillance and Evaluation |
| <input type="checkbox"/> Professional Development | <input type="checkbox"/> Language Services                |

**May we have your permission** to publish your name, agency name and e-mail in a member directory?  **Yes**  **No**

The following information is required by the US-DHHS-Office of Minority Health for funding and evaluation purposes towards eliminating Health Disparities. We appreciate your time and thank you for your cooperation.

**Continued on next page.**

Please select the categories that best describe you below:

**YOUR TYPE OF ORGANIZATION REPRESENTS (check one of the following categories):**

**A. Public Institutions (Check One):**  
Check one: Local  State  Federal  Tribal Entity/government

**B. Institutions of Higher Education (Check one):**  
Historically Black College/ University   
Hispanic Serving Institution   
Tribal college/ University   
Other College/ University

**C. Minority-Serving Community- based organization (Check one):**  
Non-health Focused   
Health Focused   
Health care entity   
Faith based organization   
Other  \_\_\_\_\_

**D. National Minority Serving Organization (Check one):**  
Non-health focused   
Health focused   
Health care entity   
Faith based organization   
Other  \_\_\_\_\_

**E. ALL: If you elected a Health Care area above, can you please specify the following for your occupation:**

- a. Community Health Worker: \_\_\_\_\_
- b. Nurse: \_\_\_\_\_
- c. APRN/PA: \_\_\_\_\_
- d. Clinical Social Worker: \_\_\_\_\_
- e. Physician: \_\_\_\_\_
- f. Administrator: \_\_\_\_\_
- g. Other: \_\_\_\_\_

Are you Community Member/ Advocate (Check if yes, specify): \_\_\_\_\_

Are you a student? (Check if yes, specify level/year): \_\_\_\_\_

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**F. INVOLVEMENT WITH THE CMHP:**

**1. How did you first learn about the CMHP?**

- Email notice       CHMP Website       CHMP event  
 Another Member       CHMP Postcard       CMHP's Educational Materials

**Other:** \_\_\_\_\_

**2. Please briefly describe the nature of skills, experiences and/or interests you/your organization intend to bring to the Partnership:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Briefly tell us your main personal or professional motivation for becoming a member of the CMHP. (I.e., what do you hope to do, or contribute to the CMHP, and what might the CMHP do for you or your organization?).**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. The CT DPH Office of Multicultural Health is compiling a list of speakers who are able to speak and present on various Multicultural Health and Disparities Issues. If you are able and interested in speaking/presenting please describe your expertise/areas of interest:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Only if applicable, are you or will you be acting as a Partner in providing the following? (Check all that apply):**

- Paid Staff      % Time if known \_\_\_\_\_      \$ contribution if known \_\_\_\_\_  
 Volunteer Staff      % Time if known \_\_\_\_\_      \$ contribution if known \_\_\_\_\_

**6. Other Resources, Please Describe:**

\_\_\_\_\_  
\_\_\_\_\_

**DEMOGRAPHICS**

**G. Geographic Area Served by Your Work (Check all that apply):**

- Fairfield County     Hartford County     Middlesex County     New Haven County  
 New London County     Litchfield County     Tolland County     Windham County  
 STATEWIDE

Continued on next page

**H. If applicable, please estimate of “race”/ethnicities and ages of the consumer populations served by your work or organization?**

**(Rank Largest to Smallest numbers of clients served for each list, using numbers # 1-7, and “0” if not applicable).**

**1. “Race”/Ethnicity:**

- Non-Hispanic/Latino- White/Caucasian
- Non-Hispanic/Latino- Black/ African-American
- Hispanic/Latino
- American Indian/ Alaskan Native
- Native Hawaiian/ Other Pacific Islander
- Asian
- Other: \_\_\_\_\_
- Optional Comments: \_\_\_\_\_

**2. By Age group:**

- Newborn to 1 year
- 1-5 years
- 6-12 years
- 13-17 years
- 18-24 years
- 25-64 years
- 65 or over

**3. Gender (Total of all percentages should equal 100%):**

- % Female
- % Male
- Other

**I. Member / Contact- Your own identified “Race”/Ethnicity:**

- Non-Hispanic/Latino- White/Caucasian
- Non-Hispanic/Latino- Black/ African -American
- Hispanic/Latino
- Other: \_\_\_\_\_
- American Indian/Alaskan native
- Native Hawaiian/Other Pacific Islander
- Asian
- Choose not to answer

**Country of Origin** \_\_\_\_\_ **Optional Comment:** \_\_\_\_\_

**J. Your Age group:**

- 13-17 years
- 18-24 years
- Choose not to answer
- 25-64 years
- 65+ years

**J. Your Gender**

- Female
- Male
- Other \_\_\_\_\_
- Choose not to answer

**PARTNERS: Please mail, fax, or email entire form (4 pages) to:**

Angela Jimenez, Office of Multicultural Health, CT Dept. of Public Health, MS #13 OMH,  
410 Capitol Avenue, Hartford CT 06106 Tel (860) 509-7140, Fax (860) 509-7160  
Email: [angela.jimenez@ct.gov](mailto:angela.jimenez@ct.gov) Form Updated 01/19/2012

**(For CMHP Staff only) Type of Membership**

- Informal/ Verbal Agreement
- Letter of Invitation/ Letter of Acceptance
- Memorandum of Understanding/Agreement
- Subcontract
- Other

**DATE RECEIVED:** \_\_\_\_\_ **STAFF:** \_\_\_\_\_

**(For CMHP Staff only)**

- \_\_\_\_\_ Total % FTEs on project (to nearest .25)
- \_\_\_ FT \_\_\_ PT \_\_\_ Consultant \_\_\_ Contractor
- \_\_\_ Fee For Service Staff \_\_\_ Volunteer (unpd.)

\_\_\_ Other: \_\_\_\_\_