POW Health Network Board of Directors Application
&
Disclosure of Interest Statement

Name:_____

Title and Organization:_____

Mailing Address: _____

Phone:_____

Email: _____

Are you willing to give a meaningful cash donation annually as part of your board commitment?

☐ Yes
☐ No

Are you available to attend a weekday and evening meeting once every three months?

☐ Yes
☐ No

Have you received a copy of the POW Health Network Bylaws and Goals and Objectives?

☐ Yes
☐ No

Are you available to attend a weekday and evening meeting once every three months?
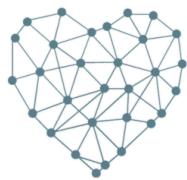
☐ Yes
☐ No

Describe below why you would like to be a member of the POW Health Network Board of Directors:_____
_____

Print Name: _____

Sign Name: _____

Date:_____

Thank you for your consideration. Please return to info@powhealthnetwork.org

Revised 1-12-2026

POW Health Network Board of Directors
Disclosure of Interest Statement

Name:_____

Mailing Address: _____

Phone Number:_____

Email Address:_____

Profession:_____

Employer: _____

Title:_____

Principal Activity:_____
Identify any business relationships, transactions or contracts between any organization and yourself, member(s) of your immediate family, or any firm in which you have a substantial interest:_____
_____
_____
Identify and list any other activities in which you, any member(s) of your immediate family, or any firm in which you have a substantial interest, are engaged in that constitute a conflict of interest:_____
_____
_____
_____

I hereby agree to file an amendment to this statement if subsequent events should cause the information contained herein to be inaccurate or misleading.

Print Name: _____
Sign Name:_____
Date: _____