

**2022 APPLICATION FOR NOMINATION TO SERVE ON THE BOARD OF TRUSTEES  
OF THE PUBLIC HEALTH TRUST OF MIAMI-DADE COUNTY**

**Mission**

To build the health of the community by providing a single, high standard of health care for all the residents of Miami-Dade County

**Vision**

To be a nationally and internationally recognized, world-class academic medical system and to be the provider of choice for quality care.

**Values**

Providing the best care, with care, for everyone by demonstrating compassion, accountability, respect, and expertise.

Chapter 25A of the Miami-Dade County Code states that the governing body of the Trust shall consist of 7 voting members, none of whom shall be employees of the Trust. Board members are appointed to the Trust during the annual appointment process or through a special convening of the Nominating Council. The membership of the Board of Trustees should be representative of the community at large and should reflect the racial, gender, ethnic and disabled make-up of the community. Candidates will be screened for any potential conflict of interest with the responsibilities of a Board member.

Completed applications and resumes can be mailed or hand delivered to the address below by **April 20, 2022 at 4:00 pm.** Emails or facsimiles of the application and resume will be accepted and can be sent to [clerkbcc@miamidade.gov](mailto:clerkbcc@miamidade.gov) or faxed to 305-375-2484. It is the responsibility of the applicant to ensure electronic receipt of the application and resume by calling the Clerk of the Board at 305-375-1652.

**Clerk of the Board of County Commissioners  
ATTENTION: Basia Pruna  
111 NW 1<sup>st</sup> Street, Suite 17-202  
Miami, Florida 33128  
(305)375-1652**

**ATTENTION APPLICANTS: BACKGROUND CHECKS WILL BE PERFORMED ON ALL APPLICANTS SELECTED FOR AN INTERVIEW. IF SELECTED, TRUSTEES WILL BE REQUIRED TO SUBMIT FINANCIAL DISCLOSURE FORMS.**



**Candidate for Nomination to Serve on the Board of Trustees  
Public Health Trust of Miami-Dade County  
Jackson Health System**

**ATTENTION APPLICANTS: BACKGROUND CHECKS WILL BE PERFORMED ON ALL APPLICANTS SELECTED FOR AN INTERVIEW. IF SELECTED, TRUSTEES WILL BE REQUIRED TO SUBMIT FINANCIAL DISCLOSURE FORMS.**

**Biographical Profile**

Name: \_\_\_\_\_  
Last First Middle

Employer: \_\_\_\_\_

Title/Occupation: \_\_\_\_\_

Business Type: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Length of Residence in Miami-Dade County: \_\_\_\_\_

**PLEASE CHECK APPROPRIATE INFORMATION LISTED BELOW (Optional)**

- |                                 |  |  |
|---------------------------------|--|--|
| <input type="checkbox"/> Male   | <input type="checkbox"/> White Non-Hispanic        | <input type="checkbox"/> American Indian or Alaskan Native |
| <input type="checkbox"/> Female | <input type="checkbox"/> Black Non-Hispanic        | <input type="checkbox"/> Haitian American                  |
|                                 | <input type="checkbox"/> Hispanic                  |  |
|                                 | <input type="checkbox"/> Asian or Pacific Islander |  |

**EDUCATION:**

School/City/Major/Degree:

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**Previous Employment and Professional Background:**

Business Name	Position	Years

**EXPERIENCE AND/OR QUALIFICATIONS:**

Describe how your past experience and/or qualifications would benefit the Public Health Trust:

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**ORGANIZATIONS AND ACTIVITIES:**

List community, civic, professional and other organizations of which you are a member:

Organization

Position Held

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<hr/>	<hr/>
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**List any Public Office held (Elected or Appointed):**

Office

Date

_____	_____
_____	_____

**Affiliations with hospitals, nursing homes or other health related institutions:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Activities reflecting community interest:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List all potential conflicts of interest, including potential conflicts arising from your relationships or the relationships of any of your family members in the healthcare industry:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**References - Persons acquainted with candidate's activities/experience:**

Name

Title

Telephone

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please describe the goals and objectives you will seek to accomplish if you are selected as a Trustee:**

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I, (candidate's name) \_\_\_\_\_,  
Citizen of the United States, a duly qualified elector of Miami-Dade County, and not affiliated with the Public Health Trust of Miami-Dade County or its subordinate agencies or institutions, would, if appointed, be willing and able to discharge the responsibilities and functions of Trustee. I declare that, if selected while currently serving on another official County board, I will resign from my other County responsibilities.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Candidate's Signature**

Nominated by (if not self):

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Telephone**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_\_  
**Zip Code**