**CAPITAL HEALTH NETWORK CLINICAL COUNCIL**

**MEMBER NOMINATION FORM**

|  |  |
| --- | --- |
| **NOMINEE INFORMATION** |  |
| Name: |  |
| Title: |  |
| Organisation: |  |
| Address: |  |
| Email: |  |
| Telephone: |  |
| **NOMINATION REQUIREMENTS-** Please review and complete the nomination documentation as outlined.  **Curriculum vitae:** Please attach a copy of your CV of no more than 3 pages.  **Statement:** Nominees should submit a statement in support of their application and no more than 250 words. Such statements should provide a brief profile including relevant experience and set out why you consider yourself appropriate for a position as a member of the Clinical Council. Please attach separately. | |

**Please return completed nomination form, CV and statement to** [boardsecretariat@chnact.org.au](mailto:boardsecretariat@chnact.org.au) **by 29 November 2024.**