**CAPITAL HEALTH NETWORK GENERAL PRACTICE ADVISORY COUNCIL**

**MEMBER NOMINATION FORM**

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| **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 General Practice Advisory Council. Please attach separately.  Key considerations may include:   1. an understanding of priority areas and issues in general practice and the ability to leverage networks to canvas views and opinions 2. a broad understanding of primary health care and the local health care system 3. the ability to prepare for, attend and participate in a minimum of three meetings each year.   **☐ Confirmation of membership**: Please complete the statement below confirming membership of Capital Health Network. | |

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, confirm that I am a member of Capital Health Network in the General Practice Class and wish to be considered for a position on the General Practice Advisory Council.

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