

Consumer Council Application Form

Please complete this form to express your interest in becoming a member of the Wairarapa District Health Board Consumer Council. Applications will be considered by a selection panel and a short list of applicants will be contacted for an interview.

Full Name:

Postal Address:

Email:

Phone Number:

Mobile Phone Number:

Why are you interested in being on the Wairarapa DHB Consumer Council?

What consumer experience would you bring to the Consumer Council?

What is your current community involvement?

What are your specific areas of interest in healthcare?

What work experience could you bring?

Other information

Please provide two referees

Full Name:

Contact Phone Number:

Relationship to applicant:

Full Name:

Contact Phone Number:

Relationship to applicant:

Successful candidates will be required to satisfy New Zealand Police Clearance and adhere to the Wairarapa DHB policies and procedures.

Please return your completed forms to:

Consumer.Council@wairarapa.dhb.org.nz

Or Post to

Consumer Council Administration

PO BOX 96

Blair Street

Masterton 5840

If you have any questions please email Consumer.Council@wairarapa.dhb.org.nz